State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2005 **Physician** Pauline Mazzu August 11:05 P M 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Nov. 13,1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F Yrs Italy 188-16-9001 92 Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1M Yes 2 No Prince George's Directo Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12202 Malin Lane 20715 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2**X**☐ No f Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify þ 3 ☐Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental I Albert Viola Josephine Lombardo 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
eny injury or other treu Bowie, MD. Josephine A. Masino / daughter 12202 Malin Lane 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 08/18/2005 Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 100 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscienotic Cerebno Vascular Disease Physician /Medical ve Condio Vascular Distan Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ ₩6 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D20108 Kath 1 OX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Lane #222 Bowie, MD. 20715 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 1 9 2005 Registrar

			1 - For State Registrar	State of M	arylar	nd / Depa <i>Cei</i>	artme <i>tifica</i>	nt of H <i>te of L</i>	ealth an D <i>eath</i>	d Me	ntal Hy	ygien. Reg. N	2005	29002
ı	Physici	an	Decedent's Name (First, Middle, Landson, Middle, Middle, Landson, Middle, Middle, Landson, Middle, M							2	Date of D Month	Di	ay Year	3. Time of Death
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	Director		213-38-4278	1□M 2∏F	65	Yrs.	Months	Days	Hours 1	Min. F	eb. 1	8,19	40 Wash	D.C.
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Maryla 1 sho	٥	MD Anne Arı	ndo1		Ri								1 □ Yes 2 □ No
	r 28e	Director	10e. Street and Number	inder		KI	_	ip Code				10g. C	itizen of What Co	untry?
	th with	a D	3203 Escapade (ircle				21	140			ι	JSA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or itema 23a or 28e-1 show aumatic event, the Model Examble Instituted by confilled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 X If Yes, Give	?			edent of Hi ecify Cubar 2 \textcal No	spanic Origin n, Mexican, P Specify:	? (Specif luerto Ric	y Yes or N an, etc.)		14. Race - Amer Black, White	e, etc.
2-0036	tural	ed to	15. Decedent's E	Year or Dates:		16a. Deced	ient's Us	ual Occupa	ition		-	16b	WII Kind of Business/l	ite
	hin 72	Completed	(Specify only highest gi Elementary/Secondary (0-12)		54)	(Give	kind of w	ork done d use retired,	uring most of	working		100.1	Cities of Desiries of	noustry
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<u>s</u>	id 2 si		Jeffery Bloxsome		ไลพ	10895	_				iel, I		or Town, State, Z ana 460:	
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumetic evente.		21. Signature of Funeral Service Lice	Dowell	2	22	. Name a	nd Addres		Bea1		nera	1 Home	
68760,	Physician be executed /Medical Examiner street burial-transit	edical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d	ne. s a conseq s a conseq	uence of):			1 Ce V		espiratory a	arrest,		Approximate Interval Between Onset and Death
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rds, P	quires that n signed b uld be deta	þ	Part II. Other significent conditions	contributing to death t	out not res	ulting in the ur	nderlying	cause give	n in Part I.	_		tobacco Yes 2		the cause of death?
Vital Records,	Physiclen: The law require this certificate has been signal al director, page 2 should b	Completed									24a. Was auto perf 1 Yes		prior to or death?	opsy findings available ompletion of cause of
ıta	clen: ertific actor,	Be (25. Was case referred to medical examiner?						26. Place of	Death (C				
on of	ng fter ner	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic	28a. Date of Inju (Month, Da	JITY	ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 🗀 Nursir				6 ☐Other (Speciary occurred	ify)
Division of	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not to determine of the determined	99 Place of In	jury - At ho tc. <i>(Specif</i>	ome, farm, stre				28f.	Location City or To		nd Number or Rui e)	ral Route Number,
	tha Hospital hin 24 hours a the Funeral I mpletely filled	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	hysicien: To the best miner: On the basis o and manner st	of examina	owledge, death ation and/or inv	occurre	at the time	e, date and p inion, death o	lace, and	due to the	cause(s	and manner as d place, and due	stated. to the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier	iil a	0			c. License	983	8		01	ate signed (Month)) (
	(5)		30. Name and address of person who	. Selou	icu,	W.C		700	Best	gate	Rd	. /	ниарс	is, ud.
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 9 200	2. Regist	rar's Signa	ature	S.							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes 29003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Sally MOSKOWITZ AVGUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENITIST HODITAL MONTGOM ROCKVILLE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Dec. 12, 1922 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2)(C) F 089-14-1184 Director New York Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Montgomery Germantown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20327 Beaconfield Terrace #102 20874 United States 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 0 1 ☐ Yes 2 ☐ No ģ Specify: 3 Widowed 4 ☐ Divorced "natural", white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unemployment Claims Processor State of New Jersey 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be f Mental and Mental Max Silverman Anna Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 if Health 19902 Silverfield Dr., Montgomery Village, MD Michael Weingarten, Son-In-Law 20886 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crescent Memorial Park 08/22/05 Pennsauken, NJ 21. Signature of Funeral Service License any In 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RESARMORY Immediate Cause (Final PAILURG **Physician** disease or condition resulting in death) 2 WKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause descriptions are the cause of the c Due to (or as a consequence of) attending physicien end for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISHASE 1 Yes 2 No 3 Probably 4 Unknown peen EDEMA, CARDIAC ARRITYTHALLAS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 this certificate has autopsy bettorme 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2√No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 136252 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11501 GEORGIA AVE. #515. WHEATON MD20902

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O. I

Division of Vital Records,

MD

2005

31. Date filed (Month, Day, Year)

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			For State Registrar	State of Maryland	Depa / נ <i>Cei</i>	triment of F tificate of	Death	мептат ну	glen 2 0 0	15 29004
			1. Decedent's Name (First, Middle, La.	et)				2. Date of De	ath	3. Time of Death
	Physicia /Medic		Stephen Ben	ton McDaniel				Augus		05 11:25 AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	th	4c. County of	of Death
			7318 Brenish 5. Social Security Number 6. S		et hirthday	Gaithe If Under 1 Year	ersburg	8. Date of Bir		gomery
	Funeral Director			M 2□F 45	Yrs.	Months Days	Hours Min.	. (Month, Da	y, Year) Q 1050	9. Birthplace (State or Foreign Country District of Columbia
	D D		Usual Residence of Decedent					nug. Z	7, 1777	
	show	ž	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits 1 🕅 Yes 2 □ No
	the M	Director	Maryland Montgom 10e. Street and Number	ery Ga	aither	sburg 10f. Zip Code			10g. Citizen of W	
	3a or			Destaro		101. 2ip C00e	20070		US.	,
	death	Funeral	7318 Brenish 11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Decedent of H f Yes, specify Cubi	20879 Hispanic Origin? (S	Specify Yes or No		- American Indian,
٥	after or ite	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	- 1	ryes, speciny Cuba I□Yes 2.2XNo	an, mexican, Puer Specify:	to Hican, etc.)	Specify:	k, White, etc.
3	be filed within 72 hours after death with the Maryland at Hygiene. A control of thy properties to the markland of the than "neturel", or terms 23a or 28a-f show other than "neturel", or terms 23a or 28a-f show event, the Madical Evanimer must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						wnite
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2	al Hygie 1 other vant,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame	9)
<u> </u>	Ment Ment Merkac	To	Thomas F. McDanie					ert Lyons		
, Maryland	and 2 sh alth and 127 is m er traum		19a. Informant's Name/Relationship (M. Eileen McDanie			g Address <i>(Str</i> eet Brenish I				State, Zip Code) yland 20879
Baltimore,	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked of any Injury or other traumatic even once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	emetery, crar ite of	sition (Name of natory or other plac Heaven	Augu	ist 23,	Silver	City or Town, State Spring,
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			23a. Part I Enter the disease, or com shoot, or heave failure. List only	plications that caused the death one cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
-	Priysician		Immediate Cause (Final disease or condition	Malignant Me	1anoma	a.				6 months
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):					
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	ii ga		IF FEMALE:	23c. If yes, outcome of pregnar	nev					
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	w requires that been signed to should be deta	by P	Part II. Dther significant conditions of	ontributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.			bute to the cause of death?
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Division	Attending Physician: rr death. actor: Atter this certific by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not b		me farm str		Yes 2 □ No	28f Location (Street and Numbe	r or Rural Route Number,
2	tel or A	Certification:	4 Homicide determined	building, etc. (Specify)	eot, factory, office		City or To	vn, State)	or ribrar riogre realiber,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 (Check only one) (Check only one) 1 Certifying Ph 2 Medical Exar	ysician: To the best of my knowniner: On the basis of examinate and manner stated.	wiedge, deati ion and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. Licens			_	(Month, Day, Year)
	12		Men	n d		2	.0542	A	ugust 19	9, 2005
	1		30. Name and address of person who Joseph 7. Catlet			·	N.W., Was	hington	D.C. 20	0010
	Sta Registr		31. Date filed (Month, Day, Year)	32 registrar's Signat			<u> </u>			

			For State Registrar	State of M	aryland / [Departme <i>Certifica</i>	ent of H	ealth a Death	ind M	ental Hygi	ene 2005	29005
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	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. C	ty, Town, or	Location o	f Death	//) - /	4c. County of Death	
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	Funeral		Social Security Number 6.		e (In yrs. last bir	thday) If Un Month	der 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign intry)
ш	Director		212-30-3631	1 ⊠ M 2□F	71	Yrs.	Days	riours	141411.	October	11 1933	MD
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Location						10d. Inside City Limits
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	Jeath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De	cedent of His	spanic Orio	in? (Spe	city Yes or No-	14. Race - Amer	ican Indian.
g	after or iter	Ē	1 Never Married 2 ☐ Married	Armed Forces? 1√2 Yes 2 ☐ If Yes, Give		If Yes, s	pecify Cubai	n, Mexican	, Puerto I	Rican, etc.)	Black, White	, etc.
<u>8</u>	rei', c	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1956	1 Ll Yes	2 ⊠ No	Specify:			Specify: W.	hite
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or items 23a or 28a-1 show event, the Medical Evaninar must be nullised at	Completed	15. Decedent's (Specify only highest of		16a	Decedent's U			of worki	na 1	6b. Kind of Business/II	ndustry
21	within iene than "	npi	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	use retired,)	0, 110,111	·9		
2	filed w Hygier other ti		17. Father's Name (First, Middle, La.	-41		Dock	Worke			<u> </u>	ACME	
and		Be	Harry L. Mellon	,						(First, Middle, M er Amey	laiden Sumame)	
Z Z	d 2 should be and Menta the standard of the standard treumatic events.	2	19a. Informant's Name/Relationship		10h	Mailing Adde	non (Strant o				City or Town, State, Zi	- 0 - 4 -)
Maryland	d 2 s 7 is treu		Darlene Smith/ni		150	2401 A				F i nksbur		
ore,	- i a =		20a. Method of Disposition		20b. Place o	f Disposition (/	Name of or other place	9) {	3/22	72005	Oc. Location - City or T	own, State
<u>m</u>	Pages nent of I ant: if its ury or o		1 □ Surial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec			on For			ns		Owings Mi	lls, MD
Baltimore,	permit. Pagi Department importent: ii any injury o		21. Signature of Feral Service Lic	Bysee,		Prit	and Affice Fur	ieral	Home	e and Ch	apel, P.A.	
		_	23a. Fart1. Enter the disease, or co	mplications that cause	d the death. Do						inster, MD	21157 Approximate
	.		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each I	ine.						31,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a		2e Spire	77	Yel	1021	5		84212
	Examiner			Due to (or as	a consequence	01).						,
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequer ce	Jf):						
	cuted od ransil	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.								
oʻ	e exe ian ar urial-t	EX	resulting in death) Last	Due to (or as	a consequence	of):						
68760,	icate be executed physician and s the burial-transit	edicai		d								
-			IF FEMALE:									
Вох	leath certifica attending pl	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death						23d. Date of deliver Month	rery Day Year
o.	The law requires that the death certifule has been signed by the attending tage 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death	5 🗌 Other	(specify)					Duy Four
م	res that the signed by be detact		Part II. Other significant conditions	contributing to death t	out not resulting i	n the underlyin	a cause dive	n in Part I.		23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	uires sign ld be	d by	A	cute Re	_	ZILVR	, ,				s 2□No 3□Pro	
Ö	w require	lete								24a. Was an	24h Wara aut	opsy findings available
Re	The lay ale has page 2	Completed							_	autopsy	prior to co	impletion of cause of
ta		e C	25. Was case referred to medical	1				00 Diana	of Dooth	1 Yes 2	□No 1 □ Yes	2 No
	Physicien: this certific ral director,	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpati	ent 2 ☐ ER/Ou	itnatient 3□	DOA Othe				nce 6 Other (Speci	(Az)
ı of	g Ph er thi	T:u	27. Manner of Death	28a. Date of Inju	ury 28b.	Time of	28c. Injury Work		-	28d. Describe ho		197
jo	Attending Indeath. Sector: After by the funer	atio	1 ✓Natural 5 ☐ Pending 2 ☐ Accident investigat		ty rear)	njury M		/es 2□N	10			
Division	i or Attend after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of in	jury - At home, fa tc. (Specily)	ırm, street, fact	ory, office		2	28f. Location (Str. City or Town,	et and Number or Run	al Route Number,
	itei or A Irs after ret Direc led in by			1								
	Hospitei 24 hours a Funerei I tely filled	edicai	(Check only 2 Medical Ex	eminer: On the basis (of examination an	e, death occurred/or investigati	ed at the tim on, in my op	e, date and pinion, deat	place, a	and due to the ca ed at the time, da	use(s) and manner as : te and place, and due !	stated. to the cause(s)
	To the Hospitel or within 24 hours after within 24 hours after To the Funerel Direct Completely filled in E	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c. License				d. Date signed (Month,	
	->-0)	tomas	RK		0	005	194		Suguet 18	2005
	48		30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type, Print)					1-1-1	/
	A.C.		1.0	22 m 29	s Stone	er pris	. 5	ite	301	rost	minster 1	MD 21157.
	Sta		31. Date filed (Month, Day, Year)	9 2005 32. Regist	rar's Signature	k L.	. M	,				
	Registr	ar	AUG 1	3 2000 July	nem s	1						

State of Maryland / Department of Health and Mental Hygiens 29006 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** nslA 14:20 PM Megness August 25 2005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth
Month, Day, Year)
5/18/1963 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 42 218-88-8151 Yrs Maryland Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MD Harford Whiteford 1 ☐ Yes 2X No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ¥. 1575 Kerr Road 21160 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 Manufacturing Carpenter other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Menta t of Health and Menta If item 27 is marked Charles Reed Magness Barbara S. Swain 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1575 Kerr Road, Whiteford, MD Sandy D. Magness/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Slateville Cemetery 8/29/2005 Delta, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 111. In the disease, or complications that caused the deal of Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, in heart tailine. List only the cause on each line. Approximate Interval Between Onset and Death Irrediate Cause (Final isease or condition resulting in death) Alveoler **Physician** Diffise DEMEGE Imonth /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, is amy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se a consequence on The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be euker 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has 2000 2 No 1 Yes Phyelcien: the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 🗌 Yes 21010 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title 29c. License number 29d. Date signed (Month, Dav. Year) MD 8 |25 |2005 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 GOO North Wolfe Sh. Bellwore, MN 21287 Magriel Town 110, Dochor's Wayne Villiam Fischer Johns Hopkins 31. Date filed (Month, Day, Year) 32. Req State 0 1 2005 Registrar

			1 - State Registrar	State of Marylan	d / Depa <i>Cei</i>	artment o	of Health a	and Me	ental Hyg	ien 2 0 0 5	29007
п			1. Decedent's Name (First, Middle, Last)				1	2. Date of Deat	n	3. Time of Death
	Physici /Medio		Betty Nichols	on				A	Month	18 200	2:50 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of			4c. County of D	eath
			200 N. Washington	St., Apt 301		Havr	e De Gra	ace		Harkon	.d
	Funeral		Social Security Number 6. Se	7. Age (In yrs. I			Year If Under	24 Hrs. 8	B. Date of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
	Director		216-24-6/62	JM 2001F	75 Yrs.	WOMEN D		be	ctober	22,1929	MD
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	laryle en	ច					_				1 Yes 2 □ No
	28a-	Director	MD Harfor	a n	aure v	e Grac			1/	g. Citizen of What	
	with se	ā	200 N. Washington	C+ An+ 201		210			'	USA	Country
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V		t of Hispanic Ori	ain? (Spec	ifv Yes or No-		merican Indian.
(0	r Her	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No	'	f Yes, specify	Cuban, Mexican	, Puerto R	ican, etc.)	Black, W	
8	rai', o	b	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I⊡Yes 2 X	No Specify:			Specify:	White
21215-0036	within 72 hours after deeth with the Marylend ene. then "neturel", or items 23e or 28e-f ehow the Medicel Exertiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	lent's Usual C	Occupation done during most retired)	t of working		6b. Kind of Busine	ss/Industry
21	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)			retired)	t or working	'		
	filed within Hygiene.	S	10		Hom	emaker				Own Hon	18
pu	tal H	Be	17. Father's Name (First, Middle, Last)					,		faiden Sumame)	
3	12 should be filed within a nad Mental Hyglene. 7 is marked other than "freumatic event, the Med	ဥ	Frank Hartman		1				ne Ste		-
Maryland	iges 1 and 2 should be filed within 72 hours after deeth with the Marylen it of Heelih and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-1 ehow or other treumatic event, the Medical Exacting manual be notified at		19a. Informant's Name/Relationship (T)							City or Town, State	
e,	1 and Heeli em 2		Irena Shrader Ex 20a. Method of Disposition			Sition (Name		uve, Da		ille, MD	21132 or Town State
JOI	nt of nt of t: if it		1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	emetery, cren	natory or othe	r place) 10	8-22-	2005	3.1/1	
Baltimore,	permit. Pa Depertmen Important: eny injury once.		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service □ cens	R. 1	· FOW	Name and A	Address of Facility	ie, P.	A	Rising Si	un, Maryland
Ba	permit. Pages 1 and 2 Depertment of Heelth a Important: if item 27 is eny injury or other tree				. 11	1 1	moon St	7 K.I.	Foard	tuneral I Sun, MV	Home, P.A.
	- T		23a art1. Enter he disease, or composhock, or leart failure. List only	tions that caused the death							Approximate Interval Between
	Physician		Immediate ause (Final disease rendition resulting death)	a	all	MYC	CAR SIA	HI.	N KARCTA	W	Interval Between Onset and Death
	/Medical Examiner		resolution dealtr)	Due to (or as a consequ	uence of):						
		in in	Sequentially list conditions,	b. Due to (or as a consequ	ience of):						
	petr Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Ć.	The law requires that the death certificate be executed tte has been signed by the attending physicien end age 2 should be detached for use as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequ	gence of):						
68760,	e be /slcie	edicai l		d.							
68	g phy as th	edi									
Вох	eath certif attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal						23d. Date of	delivery
.0	deat	sicia	in the past 12 months?	4 Pregnant at time of de		Ectopic pregr Other <i>(speci</i> i				Month	Day Year
P.0	that the de ned by the a detached f	hy	9 Unknown								
Ś	res lha igned be det	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the ur	nderlying caus	se given in Part I.		23e. Did tob	acco use contribute	to the cause of death?
Records,	w requir been si should I	Completed							1 Te	s 2 □ No 3	Probably 4 Unknown
ec	has be	pie							24a. Was an	24b. Were	autopsy findings available
		Son							perform	ed? death ☑No 1 ☐ Y	o completion of cause of ? es \$2000
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					of Death (Check only one		
of Vital	Physician: rthis certificaral director,	ို	1 163 201140	Hospital: 1 ☐ Inpatient 2 ☐ I				rsing Home	Resider	nce 6 Other (S	pecify)
		inol	27. Manner of Death SNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		d. Describe how	v injury occurred	
Sic	uttendi death. ctor: A y the fu	Icat	2 Accident investigation 3 Suicide 6 Could not be	OD - Discontinuo - Anha		М	1 ☐ Yes 2 ☐ I		f I (Ot		
Division	I or Atten after deat Director: I in by the	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, of	ffice	28	City or Town,	eet and Number or State)	Rural Route Number,
	spital ours a nerai filled		29a. Certifier Certifying Phy	sician: To the best of my know	wledge death	occurred at t	ho timo, data an	d place, an	d due to the co	uso(a) and manned	an dated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai	(Check only 2 Medical Exami	ner: On the basis of examinat and manner stated.	tion and/or inv	restigation, in	my opinion, deal	th occurred	at the time, da	te and place, and d	ue to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	0-1		29c. L	icense number		29	d. Date signed (Mo	nth, Day, Year)
)			Haman K	unde M	p.		114280	20		8/19	165
	11		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print)	1 ,	1	11-1-	11000	1
	7		Thomas Bion DO	10,3145	CUMA L	KiOW	AVK.	HAN	WO B	SACK, MI	1,21078
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2 2005	32. Registrar's Signar	haste)					/	

DHMH 17 Rev 1/2001

	Amend Items 23a PtI, 11,23,27 per ME 6851,01 / 19 / 060 in Certificate of Death	Mental Hygie		29008
Physicia	I	2. Date of Deeth	Day Zear 3	3. Time of Death
/Medica Examine	An English Name (If and institution also should and another)		4c. County of Death HOWEV	
Funeral Director	218-31-1333 Usuel Residence of Decedent		9. Birthplace Country) 1944 Vietr	e (Stete or Foreign nam
death with the Maryland rms 23e or 28e4 show	10a. State 10b. County 10c. City, Town or Location			Inside City Limits 1 ☐ Yes 2 ☑ No
r 28a-f	MD Howard Columbia 10e. Street end Number 10f. Zip Code	1.0		
ith with	10e. Street end Number 6334 Cedar Lane 10f. Zip Code 21044	10g.	Citizen of Whet Country? United Stat	
O that	MD Howard Columbia 10e. Street end Number 6334 Cedar Lane 21044 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 1 Yes 2 No Specify: 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American I Black, White, etc.	Indian,
5-00,	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wo	16t	Asia b. Kind of Business/Indust	
21215-0020 d within 72 hours af jiena. r than "natural", or the Medical Exam	3 Widowed 4 Novered Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16e. Decedent's Usual Occupation (Give kind of work done during most of work done during	orking	Film	
other vent,	17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle, Maid		
should by Manta marked	o Tinn Nguyen Hiem			
2 2 2 2	19a. Informant's Name/Relationship (Type, Print) Phuong Ho / Son 19b. Mailing Address (Street and Number or R 6828 Delafield Court,			de)
Baltimore, Noemit. Pages 1 and Department of Health Important: If New 27 any Injury or other to other	20a. Method of Disposition 1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Metropolitan Crematory	August	. Location - City or Town,	
Balti permit. Departminporta any inju	Of Cinceture of Consist Consist Mineral Consis	DeVol Fune	lexandria, V ral Home, 10 rg, MD 20877	East
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory arrest,		proximate erval Between
Physician /Medical	Complications of pulmonary embolu	IS 1	On	set and Death
Examiner	disease or condition resulting in death) Due to (or as a consequen ≥ of):	W -	1	Show
Z :=		1fec	45-1	7460
6876(flicate be g physicia as the bur		MAL PROVED BY MEDICAL EX	CAMINER	
death card	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobac	cco use contribute to the	cause of death?
dS, P.O. BOX 6i iras that the death cartific signed by the attending p d be detached for use as	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 □ Yes	2☐No 3☐ Probabl	y 4 □ Unknown
redu shoul	Status post Liposuction	24a. Was an au performed	? availab	autopsy findings ble prior to etion of cause th?
E The cata h cata h cata h		†□ Yes	Z□QV∪ 1□Ye	s 2□ No
Vitalian sicilan centificator		ath (Check only one)		
Physic of this of oral direction	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing H	dome 5 ☐ Residence 28d. Describe how in	e 6 Other (Specify) njury occurred	
ivision of Vital ratending Physician: T rate death. Irector: After this certificat n by the funeral director, p	1 Matural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division of the or Attending P affair death. el Director: Attent tad in by the funer.	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural Ro tate)	ute Number,
n 24 hou n 24 hou he Funer pletely fil	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place of the basis of examination end/or investigation, in my opinion and manner steed.	e, and due to the cause arred at the time, date	e(s) and manner as steted and place, and due to the	I. cause(s)
To the York Communication	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day,	Yeer)
2	39:Name end address of person who completed cause of death (Item 23e) (Type, Print)	M	119 16,	2005
	GUYG KATING MAN 10805 HICKNYY Kilae K	dolor	asignal	21044
State Registra	St. Date into (incl.) 240, 100, 100, 100, 100, 100, 100, 100, 1			

			- For Amend Item	State of per	Marylan Verb .	d / Depa ,C848	irtment of H	ealth and l	Mental Hygi	ene 2005	5 29009
	Physici		1. Decedent's Name (First, Middle, La Esther Bro	derick		O'Rour	ke		2. Date of Death Month August	Day Yea 20 2005	
	/Medic Examin		4a. Facility Name (If not institution, giv Frostburg Village			na	4b. Cily, Town, o	r Location of Deatl		4c. County of D	eath
	Funeral Director		5. Social Security Number 6. S		7. Age (In yrs. 1		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 6,	Year) 9. I	Birthplace (State or Foreign Country) ryland
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, it is Maryland Examination to the incilling at ance.	d by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Allegat 10e. Street and Number 19000 Latrobo 11. Marital Status 1 Never Married 2 Married 32XWidowed 4 Divorced	St. 12. Was Decedamed For 1 Tyes, Give Year or Da	Batter in U. ces?		10f. Zip Code 2152 Was Decedent of If Yes, specify Cubin	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, W	ates merican Indian, hite, etc. White
d 21215-0036	filed within 72 t Hygiene. Ither then "nett ent, Itte M. dice	• Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last	cde completed) College (1-	4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Cher	during most of wor	rking		ss/industry System
Maryland	should be ind Mental s markad o umatic eve	To Be	William J. Bi			19h Mailir	on Address (Street	Cath		akem	a Zin Code)
altimore, Ma	Pages 1 and 2 s nent of Health an int: If item 27 is iry or other trau		Catherine Davis/ 20a. Method of Disposition 1 XXeurial 2 Cremation 3 C	daughte:	20b. P	410 (The second second	w Drive,	Frostbur	g, Maryla	and 21532
Baltin	permit. P. Departme Important any injury once.		* 4 □Donation 5 □ Other (Special 21. Signature of Funeral Service Lices		Pool	22	2. Name and Addre	ss of Facility Bo	oal Funera esternpor	al Home	
8760,	Physician and // // // // // // // // // // // // //	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	used the death ch line. The properties of as a consequence of a cons	uence of):	er the mode of dyir		c or respiratory arre	st,	Approximate Interval Between Onset and Death
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á	spitel or a nours after neral Dire		29a. Certifier 1 Certifying Ph	ysician: To the	g, etc. (Specif)	wledge, deatl	n occurred at the tir	ne, date and place	City or Town,	use(s) and manner	as stated.
	vithin 24 in the Ho	Medical	(Check only one) 2 Medical Example one) 29b. Signature and title of certifier	niner: On the ba and mann	sis of examinater stated.	tion and/or in	vestigation, in my o		rred at the time, da	te and place, and d d. Date signed (Mo	
			30. Name and address of person who	Suffer cause	of death (Item	23a) (Type,		6907	A 21502	ubuj = 2:	2, 2005
	Sta	te.	Dr. Harjit Sidhu 31. Date filed (Month, Day, Year)	, 925 Bi	shop W	alsh R		erland, ^r	_{Md} . 21502		The state of the s
	Registr		AUG 23	2005	Colins of the	St. A	park				

			1 - For State Registrar	State of Ma	aryland		irtment of F tificate of		nd Me		giene	005	29010
	Physici	an	Decedent's Name (First, Middle, Last)						2.	Date of Dea Month	ith Day	Year	3. Time of Death
	/Medic	al	Thomas Malster Par							igust	21,	2005	1330 M
	Examir	er	4a. Facility Name (If not institution, give st Chester River Hospi		er		4b. City, Town, o		Death		4c. C	County of Deat Kent	h
Ī	Funeral Director		5. Social Security Number 6. Sex 1218-01-2390	7. Age	o (In yrs. ias 84	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day)2/18/	(Year)	Co	hplace (State or Foreign untry)
	ma Ma		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	cation						10d. Inside City Limits
	Maryl -f sho	ţō	MD Kent			Hall							1 ☐ Yes 2 🛣 No
	th the	Director	10e. Street and Number		11001	11011	10f. Zip Code				10g. Citiz	en of What Co	untry?
	23a c	ralD	21903 Yerkey Road				21	661				USA	
36	within 72 hours after deeth with the Marylend ene. than "natural", or items 23e or 28e-1 show ta Madical Examinar must be invitted at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Stronger	. Was Decedent E Armed Forces? 1★★ es 2 N If Yes, Give Year or Dates:	1942,	13. V	Vas Decedent of H Yes, specify Cubi	lispanic Originan, Mexican, I Specify:	n? (Specifi Puerto Ric	y Yes or No- an, etc.)		4. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	2 hour	led t	15. Decedent's Educa	tion		16a. Deced	ent's Usual Occup	ation			16b. Kind	d of Business/	industry
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	D O -	Соп	Elementary/Secondary (0-12)			Mer	chant Se					0il	
and E		Be	17. Father's Name (First, Middle, Last) Thomas M. Parks, S	r				_		irst, Middle,	Maiden S	lumame)	
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<u>8</u>	olth an 27 is r treu		Thomas M. Parks	, , , , , , , , , , , , , , , , , , , ,			Yerkey 1					21661	ip Code)
ē,	Hee Hee item		20a. Method of Disposition		20b. Plac	ce of Dispos	ition (Name of atory or other place		Date			ation - City or	Town, State
Ē	Page nent c ant: M arry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer '4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Ches	apeak	e Cremat Cente	ion (08/22	/05 S	Steve	nsvill	e, MD
Baltimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: If item 27 is marked any injury or other treumatic ex once.		21. Signature of Funeral Service Licensee	yli		F 6	Name and Addre Llows, I 30 Speer	ss of Facility lelfent	oein Ches	& Newn	am F	uneral	Home, P.A. 620
ı			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that ceused cause on each lin	the death.								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ARTORI	0504	5ROS	IS CAR	DOVA	CULA	R O	(SE)	950	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):				-			
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coras,	equire en sig									1 □ Y	es 2 🗆	No 3∏Pro	bably 4 Alphanown
Heco	The law requires thet the site has been signed by the bage 2 should be detached.	Completed					_		_	24a. Was a autops perform	y	24b. Were aud prior to death? 1 🗆 Yes	opsy findings available ompletion of cause of
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5	hysic this co	ပ္	1 ☐ Yes 2 No Hos	pital: 1 npatier		VOutpatient		4 🗀 Nursi				Other (Spec	ity)
	ding F	lon	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28	3b. Time of Injury	28c. Injun Worl			Describe ho	ow injury o	occurred	
VISION	deatl deatl ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	rv - At home	a farm stre		Yes 2 □ No	-	Location (St	reet and I	Number or Ru	ral Route Number.
2	s after s after si Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	o, ram, 3116	ot, factory, office		201.	City or Towr	, State)	VUINDER OF FIDE	as noble ivariber,
	To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director: After this certificate has completely tilled in by the funeral director, page 2.	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ien: To the best of r: On the basis of and manner stat	examination	edge, death n and/or inve	occurred at the timestigation, in my of	ne, date and p pinion, death o	place, and occurred a	due to the ca t the time, da	ause(s) ar ate and p	nd manner as lace, and due	stated. to the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	-40			29c. License	and the	0	2		signed (Month	
				MO				5750	7		8/	22/0	2
			30. Name and address of person who com	0 516	Wi	ASP11	rint) NOTE N	AVE,	cresi	ario	wy	MOZ	1620
	Sta Registra		31. Date filed (Month, Day, Year) AUG 2 3 20	32. Resistrat	r's Signatur								

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2005 Sear AUGUST 19^{ay} **Physician** JOHN MATTHEW PHILLIPS 11:03AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL WESTMINSTER 610 OAKTREE ROAD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) XX M 2 F **Funeral** Days Yrs. OCTOBÉR 12,1942 62 MARYLAND Director 219-38-9728 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nand the state by the state of the 1 ☐ Yes 2 → No WESTMINSTER Director MARYLAND CARROLL 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number UNITED STATES 21157 610 OAKTREE ROAD Be Completed by Funeral 14 Pace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1V Yes 2 No If Yes, Give Year or DatesVTETNAM 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER TELEPHONE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELEANOR IDA NOWAK WILLIAM B. PHILLIPS, JR. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SALLY A. PHILLIPS/WIFE 610 OAKTREE ROAD, WESTMINSTER, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or 20056. LAKEVIEW MEM. PARK 8/23/2005 SYKESVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility MYFRS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day 0 in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No or Attending Physicien: after death. Director: Atter this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) , 2 □ (No 2 ER/Outpatient 3 DOA 2 1 Tes 28c. Injury at Work? 28d. Describe how injury occurred 27. Many of Death 28b. Time of Certification; atural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide To the Hospitel o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) 29d. Date signed (Month, Day, Year) and title of certifier 29h Signature WIL 4+140 U(e) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. FLAVIO KRUTER 555 SOUTH CENTER STREET, WESTMINSTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar lem & specie

nysicia	ın	1. Decedent's Name (First, Middle, Last) Antwione Person						2. Date of Death Month AUGUST 2	Day '	rear .	:45 P
Medic camine		4a. Facility Name (If not institution, give str 3506 CHADWICK CT	reet and number)		4b. City To	Me Hills REST HE	Death CHTS		4c. County o	Death EGEOR	GES CO
eral ctor	0.51	5. Social Security Number 6. Sex 578-94-8626	7. Age (In yrs. la 32		If Under 1 Months	Year ff Under : Days Hours		8. Date of Birth (Month, Day, Nov • 30	Year) 972	9. Birthplace Country) Wash	(State or Fo., DC
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other traumatic event, the Medical Examiner must be justified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Morroced 15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12) 12th		16a. Decede	Yes, specify Yes 28 ent's Usual ind of work O NOT use	Occupation done during most	, Puerto F	Rican, etc.)	Specify:		k
Ic event, I	To Be Co	17. Father's Name (First, Middle, Last) Ernest W. Pers	on, Jr.					(First, Middle, M	aiden Sumame nne Brov		
eny injury or other tra		Yvonne Brown - M 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Service Licenses	moval from State 20b. Pi	lace of Disposementery, creme nony Me	ition (Name atory or oth EMOTIA Name and	Ave., for place) Il Park Address of Facility Benning	9/2/ y S	2005 tewart l	oc. Location · 0 Lando Funeral	over, l Home	State MD
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funeral d	Certification; To Be	27. Manner of Death 1	28a. Date of fnjury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	M 28	Other: 4 Nuc. Injury at Work?	ursing Hon	(Check only one ne 5 Reside 28d. Describe ho	nce 6 MOthe	ed	
completely filled in by the		4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At he building, etc. (Specify	v) wledge, death	occurred a	t the time, date ar	nd place, a	28f. Location (Str City or Town	State) use(s) and mar	nner as stated	ı.
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			1 - For State Registrar	State of M	Maryland / Depa		lealth and	Mental Hy	•	
	Physici /Medic		1. Decedent's Name (First, Middle RIGOBERTO ISM	. ,	ID PORTILI	CO		2. Date of De Month Aug 1	3 Day 2005 Yea	3. Time of Death 1:12 am M
}	Examin	er	4a. Facility Name (If not institution Univ. of Mary	land Medi	cal Syst	4b. City, Town, o Baltin	nore		4c. County of De	ath
	Funeral Director		5. Social Security Number None Usual Residence of Decedent	6. Sex 1 X M 2 □ F	Age (In yrs. last birthday) 23 Yrs.	Months Days	If Under 24 H Hours Mi	n. 8. Date of Bir (Month, Da Novemb	y, Year	irthplace (State or Foreign Country) Salvador
	r 28a-f show	rector	10a. State 10b. County	Arundel	10c. City, Town or Lo				10g. Citizen of What	10d. Inside City Limits 1 X Yes 2 □ No Country?
9003	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "netural", or Items 23a or 28a-f show event, the Midfiel Examiner is until be motified at	d by Funeral Director	7871 American 11. Marital Status 1 X Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Date:	nt Ever in U.S. 13. s?	210€ Was Decedent of H If Yes, specify Cube	lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	San Miquel 14. Race - Ar Black, Wi	,E1 Salvador
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Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It e.M.	To Be Co	17. Father's Name (First, Middle, Ruperto Por	tillo			Rosa	Maria	Maiden Sumame) Del Cid	
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Ĭ.	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		t 30 DOA Oth	OF.	eath (Check only o		
of	Phys or this eral di	-	XXYes 2 No 27. Manner of Death	28a. Date of Ir (Month, L	atient 2 ER/Outpatier	" PON	4 Nulsing		dence 6 Other (Sp	ecity)
Division	or Attending after death. Director: After	Certification:	1 □ Natural 5 □ Pendin XXAccident investig 3 □ Suicide 6 □ Could	gation 8/8/20	005 16:30	p ^M Wor	k? Yes 2⊠No	Motor	Vehicle	
Div	i Gift		4 Homicide determ	Highwa				I-97 no	orth bour	95 West at
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 X Certifyin (Check only one) 1 Medical	Examiner: On the basis and manner	st of my knowledge, death s of examination and/or in- stated.	h occurred at the tin vestigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and de	as stated. ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	,		29c. Licens 165		1	29d. Date signed <i>(Moi</i> Aug 18, 2	
;\ i	N3		30. Name and address of person	who completed cause of	f death (Item 23a) (Type,					
H4	15		James M. Feen	ev. MD 22	South Gre	ana Str	reet R	altimor	o Md 21	201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 2 2005	32. Regis	strar's Signative	,		OT CTHIOT	C, MG 21,	201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 29014 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year AUGUST 20, ETHEL ALICE LEE PINKNEY 2005 4:50A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LA PLATA CENTER GENESIS HEALTHCARE LA PLATA CHARLES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 X F Director 216-30-4880 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits iral', or Items 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 ☐ No MARYLAND **CHARLES** LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with #1 HICKORY LANE, APT. #113 20646 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ò Specify: 3X Widowed 4 ☐ Divorced "natural", BLACK Completed raumatic event, It e Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Hygiene. 8TH GRADÉ COOK FOOD SERVICE Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHARD WINTERS LEE MARY HEMSLEY LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNETTA SHORT / GRANDDAUGHTER 11992 CALICO WOODS PLACE, item 27 other t WALDORF, MARYLAND 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State = 5 permit. Page Department of Important: If any injury or once. 1 4 Donation 5 Dother (Specify) SHILOH CHURCH CEMETERY 8/24/2005 NEWBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. LEON THORNTON MO0582 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARCINOMA Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE esn. 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

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DOCK Rd, KING GEURGE, VA 22485

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30. Name and address of person w

AUG 2 2 2005

RICHARD TE 31. Date filed (Month, Day, Year) ADH KIL PARK 05-5489

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within 24 hours effer death. To the Funerel Director: Affer this certificet completely filled in by the funeral director, pa	Medical Certification; To Be Co	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigatives at 1 Suicide 4 Homicide 6 Yould not determined 29a. Certifier (Check only one) 29 Medical Examiner	TOUR	28b. Tim 7:05 7:05 7-At home, tarm (Specify) my knowledge, d xamination and/o	tient 3 DOA Other e of 28c. Injury y Work? a M 1 Y street, factory, office	at 21 es 21 No Ve 21 Ho	e 5 Residence Bd. Describe how entilator Bf. Location (Stree City or Town, 5 ospital, 8	e 6 Other (Special injury occurred trube discount and Number or Fluristate) University O. S. Charles M. d. manors as a second of the control	connected al Route Aurmber, ity Specia rles Stree
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a or 28e-f eho be notified a	Funeral Director	MD MOntgo 10e. Street and Number 10921 Inwood			Spring 10f. Zip Code 2090	12	100	j. Citizen of What Cou USA	1 ☐ Yes 2 💆
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December 19				1- For State of Maryland / Dep. Registrar Ce	artment of Health and N		iene 2005	29016
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	-		30. Name and address of person who con Pamela E. South				ot Roll	imoro M	oral ord '	21.201
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State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 200^{Yeer} **Physician** Reid Mary В. Aug. 16, 6:25 pM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) Feb. 14,1915 Kitrell, NC Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Months 1 □ M 2 □ ₩ 90 108-14-5682 Director Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. or Items 23a or 28a-f show ont: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?? is marked other than "natural", or Items 23a or 28a-f shov treumatic event, the Medical Examinal must be nutified at Fort Washington 1 Yes 2 □ No Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 401 Bogota Drive U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 表 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates: Black 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Brooks Mattie Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Bogota Drive Ft.Wash.MD. 20744 Ruth B.Little NIece injury or other 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State MD.Nat 1 Mem.Park 8-22-2005 permit. Page Department o Importent: If any injury or once. Laurel, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral Home Tromus 908 Kennedy St.N.W.Wash.D.C.20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final alk **Physician** unknow disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No detached the 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by a man in 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? We smoved 24a. Was an page 2 s has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 100 2 ER/Outpatient 3□ DOA Certification: To \$ Lis 28a. Date of Injury (Month, Day Year) 27. Manner Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After or Attending 5 Pending investigation 1 Natural after death. 1 Yes 2 🗌 No 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide Hospital within 24 hours a Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat re and tit 50459 05 person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr ess o Silver Spain 9801 Georgia Ave Registrar's Signature 31. Date filed (Mor h, Day, Year) State 1 9 2005 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Reg. N2 0 0 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VIRGINIA RHEINHARDT AUGUST 2005 10:42 A M N. 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CAMP SPRINGS 6704 BERKSHIRE DRIVE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1937 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖾 F Yrs. Director 231-42-6988 VIRGINIA 68 February 15 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow 7 is markad othar than "natural", or Items 23a or 28a-f ahov traumatic event, Ite Madical Examinari, aust be multihed all 1X Yes 2 No Director MD PRINCE GEORGE'S CAMP SPRINGS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 6704 BERKSHIRE DRIVE 20748 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter anent of Health and Mental Hygiene. aner If itam 27 is markad other than "naturat", or Ite ury or othar traumatic event, Ite Mandel Examina ury or othar traumatic event, Ite Mandel 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 YRS TRAINING COORDINATOR GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OSWALD WIMBERLY NOLA GRANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLAYTON E. RHEINHARDT/HUSBAND 6704 BERKSHIRE DRIVE CAMP SPRINGS, MARYLAND 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or '4 Donation 5 Other (Specify) ARLINGTON NATIONAL 8/29/05 ARLINGTON, VIRGINIA 21. Signature of the rat structure in see 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIOVASCULAR DISEASE Physician /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Examiner use as the burial-transit certificate be executed Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. hed signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No 24a. Was an certificate has 2 No 1 Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes __2X No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide within 24 hours a To the Funeral C cian: T 29a. Certifier X Certifying Phys the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. er: On an he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only one) tical Exami 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D0059658 August 19, 2005 30. Name and address of p rson who completed cause of death (Item 23a) (Type, Print) John Lee M.D. 6104 Old Branch Avenue Camp Springs, Maryland 20748 31. Date filed (Month, Day, Year) State AUG 1 9 2005 Registrar

			for State Registrar			te of Ma	ryland /	Depa Cer	artmen rtificate	of H	ealth a	and M		Heg. No.	200		
	Physici /Medio	an		n Rosen	thal								2. Date of De Month August	Day 18	^{Үөа} 200	5 9:0	of Death
*	Examir		4a. Facility Name Suburba	(If not institution an Hosp:	_	nd number)			,	town, or these	Location of	of Death			ounty of De		
	Funeral Director		5. Social Security 579-12- Usual Residence	-0893	6. Sex 1 [x]M 2	7 -	(In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da Sept 1,	th y, Year) 191	9. B 9 Was	irthplace (Stat Country) shingto	e o <i>r Foreig</i> n DC
	e Maryland a-f show	tor	10a. State	10b. County			10c. City, To	own or Lo									City Limits
Dakimore, Maryland 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant. Ite Modical Exarting any injury or other traumatic avant. Ite Modical Exarting in willed all once.	To Be Completed by Funeral Director	11. Marital Status 1 Never Mar 3 Widowed (Specific Status) Elementary/Sec 12 17. Father's Name Louis 19a. Informant's I Mary Re 20a. Method of Di 1 \$\overline{\Sigma}\$ Burial 4 \$\overline{\Sigma}\$ Donation	rried 2 Mar 4 Divorced 15. Deceder 15. Deceder 16. Original Properties 15. Deceder 16. Properties 16. P	12. Was Armin of the Armin of t	s Decedent Eled Forces? Yes 2 Nes, Give ar or Dates: Jeted) Jege (1-4or 5-	Navy B:	6a. Decedifie. (Give life.) 19b. Mailin 15450 a of Dispostery, create Le	Was Decedif Yes, specifi Yes, specifi Yes, specifi Yes, specifi Yes dent's Usua kind of word DO NOT uses On the State of t	10814 Lent of Highly Cubain Cocupa k done de retired, where Cocupa is considered and the considered in the cocupa is considered in the con	Specify: ation luring mos 18. Mother Ida and Number Park e)	er's Name Rai Rai Terr	ecify Yes or No Rican, etc.) ing e (First, Middle ne al Route Numb race #8- Date -2005	Inite 16b. Kin Re Maiden S 20c. Loc Adel	4. Race - An Black, Wh Black, Wh Gpecify: Who dof Busines al Est Gumame) Town, State ethes cation - City of phi, N	ces of merican Indian nite, etc. nite ss/Industry cate p. Zip Code) da, MD or Town, State	20814
ľ	Physician Physician Physician		Immediate Cause	the disease of the disease (Final	r complications only one caus	that caused se on each lin	θ.	Do not en	1800	New 1	Hamps	hire	es-Rina Ave Si	llver			0904 nate Between
	/Medical Examiner Asician and he prival-transit	icai Examiner	disease or conditions are considered to the case. Set of the United Sequentially list of ause. Enter Uncause, Disease of that initiated even resulting in death	onditions, immediate derlying a r injury	bA	Aortic Use to (or as a Nortic Use to (or as a Oue to (or as a	Disse Disse Disse	ce of): ctio:	n							6 Da	ys ears
	the death certiff y the attending iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)										23	3d. Date of d Month	delivery Day	Year	
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111000143,	The ate has page	Completed	Atrial	Fibril	lation								24a. Was auto perfo 1 Yes	osy rmed?	24b. Were prior to death		gs available of cause of
אומו כו אומו	Attanding Physician: 1 r death. actor: After this certifical by the funeral director, p	ertification; To Be	25. Was case referenced a common comm	XNo ath 5 □ Pendi invest	Hospital 28a. ng igation	1 ⊠ Inpatier Date of Injur (Month, Day	v 28	/Outpatie b. Time o Injury		8c. Injury Work	er: 4 🗆 Nu	ursing Ho	me 5 ☐ Resi 28d. Describe	dence 6		pecify)	
	in Dir	0	3 Suicide 4 Homicide			Place of Inju	. (Specify)				no deto se		28f. Location (City or To	wn, State)			umber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	(Check only one) 29b. Signature ar	2 Medicel	Examiner: Or and		examination		vestigation 290	in my or	oinion, dea		red at the time,	date and page 29d. Date	olace, and d	nth. Day, Year	
	Sta Regist		31. Date filed (Mo	P. Lawl	ess, M	D.Depa	artmen	t of	Crit	ical	Care	e Sub	ourban l	Hospfi	tal, l	_	20814 la MD

State of Maryland / Department of Health and Mental Hygiene, 29021 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Allison Roberts, Jr. 10:20 PM AUG 21 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CHARLES CIVISTA MEDICAL CENTER LAPLATA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Sept. 7, 1918 | 9. Birthplace (Standard) | 9. Birthplace (Standard) | Sept. 7, 1918 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F 578-10-4921 86 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other then "natural", or Items 23e or 28a-f show traumatic event, the Mudical Examinat mast be nutified at 1 ☐ Yes 2 No Director Maryland Charles Bryantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20617 USA 7122 Leonardtown Rd. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Tyres 2 No 1941
If Yes, Give
Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1941 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White by Widowed 4 □ Divorced 1945 perrait. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", any njury or other traumatic event, Ite Medical Exagnes, office. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Foreman Federal Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Allison Roberts, Sr. Mary Victoria Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B58 Colorado Dr., Heathsville, VA 22473 William Roberts, III/son 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 11 Acemetery, crematory or other place) 20c. Location - City or Town, State Oldcometery, crematory or other place)
Field Episcopal cem. Aug. 24, 2005 Hughesville, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A., 30195 Three Notch Rd., Charlotte Hall, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 16622 Interval Between Onset and Death perforated sigmoid colon Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** awertralitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit alvernouloses Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Consurve heart danciere coronary artisy disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown renal insufficiency 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? aportic valve replacement post Stutus 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide Fo the Hospitel within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature ag 29c. License number D46419 Name and address of person who completed cause of death (Item 23a) (Type, Print) LaPlaka MD 20646 404 Charles 5+ Charlene A Leknford MD 31. Date filed (Month, Day, Year) State Eleve Registrar AUG 2 3 2005

Physici	an_	1 - State Registrar 1. Decedent's Name (First, Middle, Las Control A Punh lo		Department of Health and Certificate of Death	2. Date of Death	g. No. Day Year 3. Time of
/Medic Examir	cal	George A. Runkle 4a. Facility Name (If not institution, give Union Hospital	street and number)	4b. City, Town, or Location of Deat Elkton	August	19 2005 1:1 4c. County of Death Cecil
Funeral Director		5. Social Security Number 6. Security Number 186-12-1694	XM 2 F 7. Age (In yrs. last bi			9. Birthplace (State Country)
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County DE New Cast		vn or Location		10d. Inside C
h with the 23a or 28 at be no	Funeral Director	10e. Street and Number 7 Hargrove Court		10f. Zip Code 19702	10	g. Citizen of What Country?
72 hours after death with the Maryland natural; or Itams 23a or 28a-f show dical Examiner must be maiffed a	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 1943-45	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 XNo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
i within 72 ho piene. r than "natur ne Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	fe completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) On the contract of the contract of wo life. On the contract of the contract of the contract of wo life.	rking	Sb. Kind of Business/Industry
be filed htal Hyg ed otha evant,	To Be Co	8 17. Father's Name (First, Middle, Last) Alphonse Runkle		Security Guard 18. Mother's Nai Edith	me (First, Middle, Ma Reno	Manufacturing aiden Sumame)
s 1 and 2 should if Health and Mer itam 27 Is marke other traumatic		19a. Informant's Name/Relationship (T Georgann Runkle/d 20a. Method of Disposition	aughter 7	b. Mailing Address (Street and Number or Richard Prove Court, New	oark, DE	19702
permit. Pages ' Department of h Important: If its any injury or of once.		1 Burial 2 Cremation 3	Entombment Laure	of Disposition (Name of try, crematory or other place) 108-2 Hill Meml. Grans. 22. Name and Address of Facility R.	4-2005	Columbia, PA
death certificate be executed Water and and and for use as the buriat-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury)	a Due to (or as a consequence	abetes hemic cardu	c or respiratory arres	t, Approxima: Interval Bei Onset and
death certific e attending p od for use as	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day
se us	þ	Part II. Other significant conditions co	ntributing to death but not resulting i	n the underlying cause given in Part I.		cco use contribute to the cause of c
Ine taw ate has b page 2 st	Completed	pacemak	et		24a. Was an autopsy performe	24b. Were autopsy findings prior to completion of c death? 1 \[\text{Yes} \] 2 \[\text{No} \]
or Attanding Priysician: In after death. Director: After this certificate in by the funeral director, pag	Certification; To Be	27. Manner of Death 1		DOA	28d. Describe how	ce 6 □Other (Specify) injury occurred and Number or Rural Route Num
- a 2 a		4 ☐ Homicide determined 29a. Certifier Certifying Phy	building, etc. (Specify) sician: To the best of my knowledge	e, death occurred at the time, date and place	City or Town,	State)
bours after naral Dire y filled in by		Check only 2 Medical Exami	ner: On the basis of examination an and manner stated.	nd/or investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s
io the trappital of Attanding Fr within 24 hours after death. To the Funaral Director. After th completely filled in by the funeral	Medical	one) 29b. Signature and title of certifier	, /	29c. License number	290	. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29023 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 14, ′ 2005^{Year} **Physician** William 7:00 A. Rosenberg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges Morningside Assisted Living Laure1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 25, 1 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1☐M 2☐F Yrs. Director 150-03-0050 86 1918 New Jersey Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show rai', or itams 23a or 28e-f shov Examinar must be notified at 1 X Yes 2 □ No Prince Georges Laure 1 Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7700 Cherry Lane 20707 U. S. A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Itams 23s any highty or other treumatic event, the Medical Examiner risat once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. IXIYes 2 □ No 1941 — 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Sales Manager Liquor and Tire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Rosenberg Dora Itzikman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris M. Cooper - Daughter 2407 Griffen Street, Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 XRemoval from State D. C. Lodge Cemetery 8/17/2005 Washington, D. C. ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald 20852 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last nding physicien and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown is been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No this certificate No No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other 4 Nursing Home 5 Residence 6 Other (Specify) Assisted Hospital: 은 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide filled in within 24 hours a To the Funerel L 29a. Certifier 1🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 16, 2005

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) State 19 2005 Registrar

32 Registrar's Signature

D26287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Berard M. D. 7305 Baltimre Blvd., # 107, College Park, Md 20740

		1 - State	Oldio of Mi	Ce	rtificate of L	Death	,	Reg. No.	000	23024	
		Registrar 1. Decedent's Name (First, Middle, Las	t)		71,770410 07 2		2. Date of De			3. Time of Death	
Physi	cian dical		D.		RICHMA	N	08/12/		y fear	5:23 A	
Exam		A. Escilla Name (Managements)	street and number)		4b. City, Town, or	Location of Death)	4c.	County of Death	n	
		SHADY GROVE ADVENT			111111111111111111111111111111111111111	ROCKVILL				GOMERY	
Funera Directo		5. Social Security Number 6. Sec 13 15 3 - 46 - 4504	x 7. Ag ∑M 2□F	e (In yrs. last birthday, 49 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	1955 1955		nplace (State or Foreig Intry) JERSEY	
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limit	
Aarylan f show	5	MARYLAND MONTGOME	7RY		GAITHER	SRIIRG				X□Yes 2□N	
the 1	Director	10e. Street and Number	11(1		10f. Zip Code	DDORG		10g. Cit	izen of What Cou	untry?	
23s or			EAST APT1	60		20878			U.S.A	Α.	
after dea or Items	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi	spanic Origin? (S	pecify Yes or No	>-	14. Race - Amer Black, White	ncan Indian,	
	2	3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Dates:		1 ☐ Yes 🏋 No		Specify:	WHITE			
72 hours natural', dical Exc	Completed	15. Decedent's Ed	ucation de completed)	(Give	edent's Usual Occupa e kind of work done d	furing most of wor	king	16b. K	ind of Business/l	ndustry	
ithin ithin	a cu	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired,)					
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2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental Hygiene.	To Be	MEGULET BEGINAN				MARION E		, maioon	Comamo		
d 2 shou th and M 7 is mar traumat		19a. Informant's Name/Relationship (7 MICHAEL RICHMAN/FA	* .		ling Address (Street a					ip Code) 07067	
is 1 and 2 of Health Item 27 other tra		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	0)	Date	20c. Lo	ocation - City or	Fown, State	
Pages nent of l	h	1 ★Burial 2 ☐ Cremation 3★☐ 4 ☐ Donation 5 ☐ Other (Specify			NON CEMETE	l l	/2005	TSET	TN NFW	IFRCEV	
permit. Pages Department of I Important: If Ite	الع	21. Signature of Funeral Service Licen			ZANZANSKY						
Page 2	ă	1 Claston)		170 ROCKV						
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause one cause on each li	the death. Do not er	nter the mode of dying	g, such as cardiad	or respiratory a	ırrest,		Approximate Interval Between	
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/Medica		resulting in death)		a consequence of):							
Examine		Sequentially list conditions,	D	CARDITIS/E	PERICARDIT	IS				6 WEEKS	
ed isit	e di	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury ATDS WITH WASTING SYNDROME.									
cate be executed physician and the burial-transit	Fyamin	Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
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ortificate be executed ing physician and as the burial-transit	Medical										
ath ce	Physician/M		23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year	
res that the de ignad by the a			ontributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did	tobacco	use contribute lo	the cause of death?	
sign lid be	yd by	HIV NEPHROPATHY W	TH RENAL	FAILURE			1 🗆	Yes 2.	X No 3□Pro	obably 4 Dunknow	
w requir s been s should	ioto	HIV ASSOCIATED PAR	NCYTOPENIA				24a. Was		24b. Were au	topsy findings available	
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an: antrifice	a	25. Was case referred to medical	LIN OMNONI			26. Place of Dea					
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ding Ph After thi funeral			28a. Date of Inju (Month, Da	ury 28b. Time Injury	Work		28d. Describe	how injui	ry occurred		
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of or Attendi after death. Director: A d in by the fu	Cortification.	4 Homicide determined	200. Flace of III	jury - At home, farm, s ic. <i>(Specify)</i>	treet, factory, office		City or To			rai nodie Ndriber,	
LIVISION OF VICA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, i	O legipa	37	ysician: To the best niner: On the basis of and marrier st	of my knowledge, dea of examination and/or i ated.	ath occurred at the timinvestigation, in my op	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) , date and) and manner as d place, and due	stated. to the cause(s)	
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F		30. Name and address of person who				/FO DCC		364=		0050	
		MICHAEL A. SAURI,	MD 15005	SHADY GRO	OVE KOAD #	450, ROC	KVILLE,	MAR'	YLAND 2	20850	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 19 2005

			1 - For State Registrar	State of Ma	aryland / E	Depar Cert	tment of H ificate of L	ealth and Death		Heg. No	200	5 2	9025	
г	Physici	an	1. Decedent's Name (First, Middle, La Betty Jane Ra	^{st)} nkin					2. Date of De Month	eath Da	y Yea		ne of Death	
	/Media	cal	4a. Fecility Name (If not institution, giv				4h Cihi Taura	Leasting of Day	August				55 P M	
/**	Examir	ier					4b. City, Town, or		ain	40.	County of De			
	- Funeral		Shady Grove Advertiles. Social Security Number 6. S	Sex 7. Age	ing & Re e (In yrs. last birt	hday)	Rockvil If Under 1 Year	If Under 24 Hr			Montg	irthplace (St	ate or Foreign	
	Director		194-14-3927	□ M 2 ½ F	82	Yrs.	Months Days	Hours Mi	June 8			Co <i>untry)</i> ennsyl		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loca	ition					10d Insi	de City Limits	
	f sho	ō	,	gomery	Rockvi		ttion .						Yes 21 No	
	28a-	rect	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ROOM		10f. Zip Code			10a Cit	izen of What (
	h with		14318 Oakvale S	treet			20853				SA	odiniy.		
26	s after deat or Iteme 2		11. Marital Status 1 □ Never Married 2 🕱 Married	12. Was Decedent B Armed Forces? 1 Yes 25 N If Yes, Give		Specify Yes or No arto Rican, etc.)				n,				
Ş	tural',	d be	3 Widowed 4 Divorced	Year or Dates:	10-		Yes 2 XNo	Specify:						
-6121	yidilid ZIZION ould be filed within 72 h Mental Hygiene. arked other than "natu	omplete	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	College (1-4or 5		(Give kii life. DC	nt's Usual Occupa nd of work done d NOT use retired,	ition furing most of w	orking		ind of Busines	,		
		Ü	17. Father's Name (First, Middle, Last)				ckeeper	18. Mother's Name (First, Middle,			Publishing Maiden Sumame)			
<u>a</u>		0 8									e, Malden Sumame)			
a Z	shot s ma		19a. Informant's Name/Relationship (Гурө, Print)	19b.	Mailing	Address (Street a	nd Number or F	Rural Route Numb	er, City o	r Town, State,	Zip Code)		
	and 2 ealth n 27 I		Raymond B. Rankir	ı/ Husband	14	1318	Oakvale	Street	, Rockvi	lle,	Maryla	and 20	853	
	Pages 1 ment of H ant: If Itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			y, crema	ion (Name of tory or other place L Cemetery	Aug	gust 20 2005		eation - City of			
Ball	permit. Departr Importa any Inji		21. Signatury of Funeral Service Licer	100		Fra	Name and Addres	Colling	s Funeral	l Hor	ne Inc			
	/Medical		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	J CANCI	the death. Do note.	ot enter	the mode of dying PAN CR	, such as cardia	ac or respiratory a	rrest,		Approx Interval Onset a		
3/00,		Ical Examiner	Saturation of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): d.											
The law requires that the death certificate be executed X S of Dearth of Hath and Mental Hygiene. The law requires that the death certificate be executed X S S of Dearth of Hath and Mental Hygiene. The law requires that the death certificate be executed X S S S S S S S S S S S S S S S S S S	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							2	23d. Date of do Month	elivery Day	Year			
S, T	uires that signed to Id be deta	þ	Part II. Other significant conditions of SEPS IS	ontributing to death bu	ut not resulting in	the unde	erlying cause give	n in Part I.			se contribute			
COAL	he law req a has beer ge 2 shou	mplete	HYPOTHYR	OIDISM					24a. Was autop		24b. Were a prior to death?	completion	ngs available of cause of	
5	n: Ti ficate or, pa		25 Was some referred to medical						1 ☐ Yes	2 🔀 No		s 2□No		
=	s cert irect		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Out		Otho		eath (Check only o					
	g Phy er thi	-	27. Manner of Death	28a. Date of Injury (Month, Day		ime of	3 DOA 28c. Injury Work	4 Living	Home 5 Resid			ecity)		
5	ath. r: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		rear) In	jury		? es 2 □ No						
2	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc.	ry - At home, fare . (Specify)	m, street	, factory, office		28f. Location (5 City or Tox	Street and vn, State)	d Number or F	Pural Route	lumber,	
	To the Hospital or within 24 hours aftr to the Funeral Discompletely filled in	Medicai	29a. Certifier (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner stat	examination and	death or	ocurred at the time tigation, in my opi	e, date and plac nion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the caus	se(s)	
	To with Com	Σ	29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Mon	th, Day, Yea	r)	
	5		1				D28	656		Augu	st 18,	2005		
			30. Name and address of person who on Ravi Passi, M.D.	completed cause of de 8609 Sec	ond Ave	Type, Pri	Silver	Spring,	MD 20910					
	Star Registra	_	31. Date filed (Month, Day, Year)	32. degistra	r's Signature	dis	de .							

State of Maryland / Department of Health and Mental Hygien 200529026 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 130 Henry McClean ru G Ragsdale 2-00-5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HUS817AL AGNES If Under 24 Hrs mo 8. Date of Birth (Month, Day, Year) Nov. 20, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Days Months Hours 1XM 2□F 1923 Maryland Director 577-24-6565 81 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 28a-f show r than "natural", or Itams 23a or 28a-f shov tre Medical Examiner must be notified at 1 Yes 2 No Director Maryland Howard **Elkridge** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6391 Rowanberry Drive #318 21075 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩₩II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ¼ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ns any Injury or other traumatic event, ILA Meuls 2002. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Federal Government 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard R. Ragsdale Mabel C. Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Ragsdale Garland/daughter 3132 E. Stone Point Dr. Boise, Idaho 83712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 20, 1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2005 W. Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 20129 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician EPTICE MIA MONTH /Medical Due to (or as a consequence of) Examiner NEUMONIA MONTH Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit teme NNGESTIVE Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No rojomyo Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DUODENM this certificate has autopsy performed G EEDIA 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After t or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide uneral lospital hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel ATTEN DIN G 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D57216 Aug 19 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.G. CATON AVE, BALTIMORES SAH 900 BAMOS , ball egistrar's Signature 31. Date filed (Month, Day, Year) AUG 2 2 2005 32 State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 29027 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18,2005 Viola Reyes August 7:40a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Knollwood Manor Millersville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Yrs. Director 285-12-6486 Ohio Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 77 is marked other than "naturel", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1106 Red Falls Lane 21054 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene.
Is marked other than "naturel", or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2\(\time{X}\)No Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Technician Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael King Katherine Szegedi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is n any Injury or other traum 2005e. Carroll Mobley (Daughter) 1106 Red Falls Lane, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-19-2005 Baltimore, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P. Amb 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardio vascular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. East the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit certificate be executed Due to (or as a consequence of): the attending physician Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. I 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by DEMENTIA 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 XNo 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Chack only one) 29b. Signature and title of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print)

C. WALLACE, My 9005 KILBRIDE RD, BALTIMORE, MD ILZ3L

y, Year)

32. Registrar's Signature

16 1 9 2005 and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registra: 29028 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Jannie Marie Rogers 2005 August 17 1732 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 79 Yrs Director 212-22-2429 April 10, 1926 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Directo 1 Yes 2 No MD Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 6364 West Shady Side Road Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23 Completed by Funeral 20764 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Anne Arundel County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Eugene Bowen Hattie Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau once. Mary Kitchen (Daughter) 4736 Frederick Avenue, Shady Side, MD 20764 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 8-23-2005 Crownsville, MD 21. Signature of Euneral Service Licensee 22 Name and Address of Facility Hardesty Funeral Home, P.A. Datruck 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Multi 5 1stem organ /Medical Due to (or as a consequence of). Examiner tonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical ettending p JE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Xinpatient Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical PSCENTING Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year, 124804 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson MD

DHMH 17 Rev 1/200

State Registrar AUG 1 9

32. Paistrar's Signature

State of Maryland / Department of Health and Mental Hygien 2005 29029 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OS. 35 Kabiner Zelda 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Mi) Levindale If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 214-05-1842 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 □ Months 86 Director April 15,1919 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location ir items 23a or 28a-f show direct ust be notified at 10d. Inside City Limits MD BALTIMORE Completed by Funeral Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2500 WEST BELVEDERE AVE USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: if item 27 is marked other than "neturel", or iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE other treumatic event, the Mudical Example 1 ☐ Yes 2 ☐ No 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) SECRETARY 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOV'T 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KOTZIN LOUIS LENA ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 BARRINGTON FARE ROCKVILLE MD 20850 Department of Health a important: if item 27 is eny injury or other tre once. SHELDON KOTZIN NEPHEW 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Aug 14,2005ANNAPOLIS MD Kneseth Israel Cem ^¹ 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Hardesty Funeral Home P.A. 12 RIDGELY AVE ANNAPOLIS MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) EMILURE TO /Medical Due to (or as a consequence of): Examiner DGRESSIVE EMENTIA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit UROSEPSIS that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 24 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063327 Slum H. WINEHUUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Ave, Baltimore MO 21215 WOLDEHOWOT 2434 31. Date filed (Month, Day, Year) 32. Refistrar's Signature

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2005

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R	(15)		30. Name and address of person who completed c	ause of death (Item 23a) (Ty	rpe, Print)	1 10.1	1010	0/	24.0
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State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician August Patricia Alice 5:35A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept. 14,1919 9. Birthplace (State or Foreign **Funeral** Months Days Hours 85 Min 537-16-2585 Yrs. Washington Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at Maryland Carroll Funeral Director 1 Yes 2 No New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e or 312 Church St. 21776 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 Nidowed 4 Divorced "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4gr 5+) homemaker own home permit. Pages 1 and 2 should be file Department of Health and Menial Hy Importent: If Item 27 is marked othe eny injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Frank William Garske Carrie A. Locke 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Stalfort/personal rep. 18912 Middletown Rd. Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Nother (Specan tombment Pipe Creek Cemetery 8/24/2005 nr. Linwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home affarine 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Privolcian nemor erepral Minutes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 Yes 2□ No this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 2 Accident 3 Suicide 8-21-05 0055 AM 1 Yes 2 No Fell From Director: ,d in by the f 28f. Location (Street and Number or Rum I Route Number. City or Town, State) 312 Curch St. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide New Windsor, mg within 24 hours a Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WJL August 22, 2005 00051924 12 Name and address of person who completed cause of death (Item 23a) (Type, Print) ! Henderson Jamo 2973 Manchester RJ Manchester MN 21102 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 2 2005 Registrar

Funeral

Director

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DINS	th with the	23a or 28	ai Dire	10e. Street and Number 500 TREMONT DRIVE	APT. 4
Smerowsk -0036	Pages 1 and 2 should be filed within 72 hours after deeth with the N	Hygiene. other then "naturel", or iteme 23a or 28e-i rent, it e Medical Examitrational De Fruiti	Completed by Funeral Direct	11. Marital Status 1 Never Married 2 Married XX Widowed 4 Divorced	12. Was Decedent Armed Forces? 1XXYes 2 1 If Yes, Give Year or Dates:
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M Sm 21215-0036	within	rthen.	iduc	Elementary/Secondary (0-12)	College (1-4or 5
and	d be filed	ed other ced other c event,	Be	17. Father's Name (First, Middle, Last) JOSEPH M. SMEROWS	
Maryl	log Shoul	Ith and Menta 27 is marked treumatic ev	2	19a. Informant's Name/Relationship (MARILYN WANDA/COU	
Joseph Baltimore, Maryland	permit. Pages 1 a	Department of Health and Mental Hygiene Importent: If item 27 is marked other the any injury or other treumatic event, Ite N <u>once.</u>		20a Method of Disposition **ABurial 2	-
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O. Box 68760	he death certificate be executed	r the attending physician and ched for use as the burial-transit	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown

1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOSEPH MICHAEL SMEROWSKI **Physician** Month 6.05 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hunder 24 Hrs. NIA VA Medical saltimore 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday If Under 1 Year Date of Birth Month Day, Year, SEPT 22, 9. Birthplace (State or Foreign Days 10XM 2□ F Hours 218-44-6487 60 Yrs. 1944 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYT.AND CARROLI WESTMINSTER 1 Yes 2XXVo 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 21157 Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Nο 1 ☐ Yes **②XX**No Specify: WHITE VIETNAM 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry +) MACHINIST TOOL MANUFACTURING 18. Mother's Name (First, Middle, Maiden Sumame) MAY C. RUPERTI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1825 E. MAYBERRY ROAD, WESTMINSTER, MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State GARRISON FOREST STATE VETERANS CEMETERY OWINGS MILLS, MD 8/19/2005 MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, P.A. 21157 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death SIS 2 weeks consequence of): a consequence of) a consequence of): of pregnancy 2 Petal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of Certification: 28c 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 30. Name and address of purson who completed death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

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Registrar

or Attending Physicien: The law requires that

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within 24 hours after death.

To the Funerel Director: A comoletely filled in by the ft.

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To the

To Be

Division of Vital Records,

ORIGINAL

Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or iteme 23a or 28a-1 show eny injury or other traumatic event. It is Medical Examinite must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funerei Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

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State

CASILICE

111 Penn Street, Baltimore, Maryland 21201 31. Date liled (Month, Day, Year)
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who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 29034 1 - Stete Registre Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** P^{M} 15, 2005 Gene Austin Stoneman 10:51 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year B. Date of Birth Social Security Number **Funeral** Days Months Hours Min 1 XM 2 ☐ F 6-12-1930 Virginia 75 213-24-4199 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Edgewater Maryland Anne Arundel Director 10e. Streel and Number 10f. Zip Code 10g. Citizen of Whal Country? USA 1626 Midland Rd. 21037 by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any Injury or other traumatic event, the Medical Exemina 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates: 1954–62 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) P.G. County Government Locksmith 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Haddy A. Frost Ernest V. Stoneman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1626 Midland Rd., Edgewater, MD 21037 Peggie Lue Stoneman/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, Slate 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 8-19-05 Cheltenham, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signal of Funeral Services 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Myola **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physicien and shed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobaccouse contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 2 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death [Check only one] examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dalient 2 2 ER/Outpatient 3 DOA After this 27. Manuar of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending Injury 1 Yes 2 No death. 2 Accident investigation within 24 hours efter deat To the Funeral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 1 Certifying Physician: Forme begins my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29c. License number 29d. Date sign-d (Month Day, Year) 29b. Signatule 05 D43080 30. Name and address of p of de th (Item 2012 31. Date filed (Month, Day, Year) State AUG 1 8 2005

DHMH 17 Rev 1/2001

Registrar

Physici		Registraramend item # 1. Decedent's Name (First, Middle, Last Escolastico	State of Maryla 44a per me g8 G.	47-9707	705 JH gatan		2. Date of Death Month	Day Year 29, 2005	3. Time of Death	
/Medio		4a. Facility Name (If not institution, give 7901 VELTRI ROAD 5. Social Security Number 6. Se		. last birthday)	4b. City, Town, or TEMPLE If Under 1 Year	Location of Death HILLS If Under 24 Hrs.		4c. County of Dea	ath EORGES	
Funeral Director			¥M 2□F 60	Yrs.	Months Days	Hours Min.	Feb. 10, 19		nthplace (State or Forei country) nilippines 10d. Inside City Limi	
Hygiene. uther then "naturel", or lieme 23e or 28e-f show ent. the Mudical Examiner must be notified at	Director	Maryland Prince Ge	orge's	Ft. Wash	10f. Zip Code		10g.	. Citizen of What C	1 ☐ Yes 🔏 🔽 N	
dal Hygiene. 5d other than "naturel", or lieme 23a or 28a-f show event. Its Mudical Examiner must be notified at	by Funeral Director	7901 Veltri Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed ***Systycrced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1	207444 Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	USA 14. Race - Am Black, Whi		
ene. then "naturel to Medical Ex	Completed b	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occupa kind of work done of OO NOT use retired Body Repa	luring most of work)	ing	o. Kind of Business	s/Industry	
n and Mental Hygiene. 7 ie marked other then iraumatic event, the Mental iraumatic event.	To Be Co	17. Father's Name (First, Middle, Last) Francisco Sugatan				18. Mother's Name	e (First, Middle, Mai na Gerbuyos	den Sumame)		
r Health and Men Itam 27 le marke other traumatic		19a. Informant's Name/Relationship (Ty Hans E. Sugatan / Son		24618	3 Nettle Mil		al Route Number, Ci tone Ridge,			
rtant: If		20a. Method of Disposition 1 XXBurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, cren urrection	sition (Name of natory or other place n Cemetery	09/03/		inton, Mary		
tmpo eny ir once.		21. Signative Fune by Service Licens: 23a. Parti. Enter the disease, or complishock, or heart failure. List only or	7	63		11 Road Oxo	ge P. Kalas n Hill, Mar	Funeral Hoy yland 2072	me P.A.	
ysician and ledical aminer transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of): Quence of):	the liv	er			Onset and Death	
ed by the attending pt detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous	ıl death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year	
50		Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause give	n in Part I.	23e. Did tobacc	cco use contribute to the cause of death?		
ate has	Completed						24a. Was an autopsy performed 1 20 2 1	? prior to death?	utopsy findings availab completion of cause o	
his d	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At houlding, etc. (Specif	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 \(\sup Y	at 2 No	me 5 ☐ Residence 28d. Describe how in 28f. Location (Street City or Town, St	and Number or Ru		
To the Funaral D completely filled in	ledical Cel	29a. Certifier (Chock only one) 1 Certifying Physical Examination (Chock only one)	ician: To the best of my kno	wledge death	occurred at the time	e, date and place, a	and due to the cause	v(s) and manner as	stated.	
Fo the		29b. Signature and the oil certifier	and manner stated.		29c. License	number	29d. I	Date signed (Monti	h, Day, Year)	
,			X		O.C.M	. E.	+ AUG	JUST 30,2	005	

State of Maryland / Department of Health and Mental Hygien 29036 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2005 Frances A. Teal 19, 9:10A August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Sandy Spring Friends Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months 1 □ M 2 □ XF August 6 1903 North Carolina 102 Director 578 44 5478 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, Ita Marical Examinar must be notified a page. 1 ☐ Yes 2XXNo Director **Brookville** Maryland Montgomery 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code USA 20833 #9 North Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. □Yes 2NNo 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give The Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Teacher 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Lee Campbell H.O. Alexander 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 North Street Brookville, Maryland Fred T. Teal / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 8/23/2005 Charlotte, N. Carolina Providence Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Lice see 11800 New Hampshire Ave Silver Spring, MD 20904 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Weeks Immediate Cause (Final Dysphasia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2□ No Hospital or Attanding Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) lhis 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 5 Pending after death. investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MM D23124 August 19, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis M. Hannon, M.D. 2901 Olney Sandy Spring Road Olney, Maryland 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State 22

DHMH 17 Rev 1/2001

Registrar

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2005

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar 29037 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Gilbert Dennis Thurston Sr. August 845 AM /Medical 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death dedy molly NURSING Home Washington 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 M 2 ☐ F Hours Min. 220-16-1053 Director Yrs. Jan. 23, 1926 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show orient: If item 27 is marked other then "naturel", or items 23a or 28a-f sho ir jury or other treumatic event, the Medical Examinar must be motified at 10d. Inside City Limits Md. Washington Directo 1 ☐ Yes 2 ☐ No Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 14119 Maugansville Rd. 21767 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permi. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: If item 27 is marked other then 'any injury or other treumatic event, the Means. Elementary/Secondary (0-12) College (1-4or 5+) Administrative 12 Crane Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William T. Thurston Catherine F. Wasson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Twila B. Thurston (Wife) 14119 Maugansville Rd. Maugansville, Md. 21767 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Aug. 29, Smithsburg Crematory 4 Donation 5 Other (Specify) Smithsburg, Md. 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Mol4/4 J.L. Davis Funeral Home Smithsburg, Md. 21783 AUIS Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinamo NOSO PAYLYNERA disease or condition resulting in death) /Medical Due to (or as a obnsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury m Due to (or Physician/Medical Examiner physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 Yes 2 No 1 Tyes the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 KNursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending after death. investigation 1 Yes 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel within 24 hours a To the Funerel [29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0.7535 325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Occ. 32. Registrar's Signature malic Hagerstown M.D 21740 Date filed (Month Year) State 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 29038 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Natalie Haight Latimer Underwood 20, 2005 11:07 A M August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chester River Manor Kent Chestertown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 069-22-4426 Director 7.7 02/13/28 DE Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event. It is Modical Examiner must be muitient and sonce. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Kent 12€XYes 2 □ No Chestertown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 South Queen Street 21620 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2CXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 200No Specify: White Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Henry Latimer Natalie Peabody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Underwood/husband 309 South Queen St., Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 TBurial 2 Cremation 3 Removal from State St. Paul's Cemetery 08/27/05 1 4 ☐ Donation 5 ☐ Other (Specify) Chestertown 21. Signature of Funeral Service Ligensee 22 Name and Address of Eacility Fellows, Helfenbein & Newnam Funeral Home 130 Speer Road, Chestertown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to initial adaptacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 00 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy certificate 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2XNo Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 7 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this Director: After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title AUGUST 23 2005 D0051786 30. Name and address of person o completed cause of death (Item 23a) (Type, Print) 120 Speer RD Bldg B Chestertown MD 21620 Andrew Forguson MD
31. Date filed (Month, Day Year) State

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Registrar

AUG 2 4 2005

Please Type or Print in Black indelible ink. Ensure All Copies are Legible. State of Maryland / Department of Health and Mental Hygien 2005 29039 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:45a M AUGUST 2005 BLACK VOORHEES RUTH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Chester River Hospital Center Chestertown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2√2 F 93 144-07-2902 14 1912 New Jersey Director Mar Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f ahow the Medical Examiner must be notified at 1- Yes 2 □ No Director Chestertown MDKent 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Items 23a 303 Heron Point Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 212 No Specify: If Yes, Give 25. Year or Dates: Specify: White ρχ 3 ₩idowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 ia marked othe any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward Everett Black Belle Dudly deVausney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21645 19a. Informant's Name/Relationship (Type, Print) Charles E. Voorhees (son) 14136 Kentmore Park Rd. Kennedyville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/23/05 Kent Cremation Smyrna, DE. 21. Signature / Furreral Servic-L. Schaec 21635 Galena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACCIDENT CEREBROVASCULAR Priysician Oday. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 2 🗆 No FIBRILLATION OSSTRUCTIVE PHLMONARY DISEASE 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 200 No 1 Yes 1 Yes 2 200 Division of Vital it or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Enpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitat o within 24 hours aff To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $M \cdot D \cdot$ 122 Speer Rd. Chestertown, MD. Noble, Helen A. 32. Registar's Signature 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

			For State Registrar	State of Ma	arylan	d / Depa	artmer	nt of H	ealth and	Mental H	ygiene Reg. No.	2005	29040
	Physicia	an	1. Decedent's Name (First, Middle, La Dorothy Virgi		ite					2. Date of D Month			3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv		II CE		4b. City	Town, or	Location of De	ath O	4c.	County of Death	
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	Funeral		 Social Security Number 6. S 	ex 7. Age	e (In yrs. I	ast birthday)	If Unde	r 1 Year	If Under 24 H	s. 8. Date of B	irth	9. Birth	place (State or Foreign ntry)
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
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	r 28a	Director	10e. Street and Number					p Code			10g. Cit	izen of What Cou	intry?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, If a Madical Evan	ai D	200 Civic Ave.					2180			US	A	
	r dea	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Dece If Yes, spe	dent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or North Rican, etc.)	10-	 Race - Amer Black, White 	
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Baltimore,	Page: nent o nt: tf		1, ∠Burial 2 □ Cremation 3 □ 1, 4 □ Donation 5 □ Other (Special			rsons				24/05	Sal	isbury,	MD
alti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		71. Signature of Funeral Service Licer						s of Facility	Homo Dro	ofoac	ional A	ssociation
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		4	For State Registrar			tificate of E			Reg. N	ist,	2901.1
			Decedent's Name (First, Middle, Last,		-			2. Date	of Death	ay Year	3. Time of Death
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	with t	Funeral Director	10e. Street and Number 29269 Naylor Mi	ll Road		10f. Zip Code 2180	1			J.S.A	ountry :
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9	after or itan	Fur	1 Never Married 2 Married	Armed Forces? 1 Yes 2 □ No If Yes, Give		f Yes, specify Cubar 1 □ Yes 2 X No	n, Mexican, Specify:	. Puerto Rican, e	tc.)	Black, Whi	ite, etc.
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Baltimore,	Pages nent of h ant: If ite ary or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Admoval Holli State		sition (Name of natory or other place	1	9-1-05			
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			1 - For State Registrar	State of Marylar	nd / Depa		t of H	ealth a		ental Hy		20		2904
ı			Decedent's Name (First, Middle, Last)							2. Date of De	ath			3. Time of Death
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	Funeral		5. Social Security Number 6. Sex	M 2□ F	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da	y, Year)		Birthplace Country)	e (State or Foreign
	Director		219-36-5554	65	Yrs.				(Oct. 31	, 19	39	Mary	land
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation							10d.	Inside City Limits
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	death	Funeral		12. Was Decedent Ever in U Armed Forces?	J.S. 13.			spanic Orig	gin? (Spec	fy Yes or No ican, etc.)	-	14. Race -		
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8	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "neturel", or items 23a or 28e-1 ehow event, it e Midfred Examiner must be mutilised at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			20110	ороопу.				Specify:	Black	<
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aŭ	d be antal	o Be	Russell Garrison Whi	te. Sr.					a Pet			,		
Maryland 21215-0036	Shoul nd Me mark	2	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address	(Street a			Route Numbe	er, City o	r Town, Sta	te, Zip Co	de)
Š	nd 2 :		Margie Baker White/			-				stertow	-			,
ē,	s 1 au f Hea item othe		20a. Method of Disposition	20b. i	Place of Dispo cemetery, crer	sition (Nan	ne of ther place	0)	Da	te	20c. Lo	cation - Cit	y or Town,	, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturet", or items 23a or 28e-1 ehow any injury or other traumatic event, if a Wicifial Examiner must be notified at ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval mom State					8/29/	2005	Farm	ville	Mort	th Carolina
Ħ	mit. partm porta / inju		21. Sign ture of Funeral Service License		22	2. Name an	d Addres	s of Facility	1213	Jersev	Roa	d - S	alishi	ury, MD
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			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deal	th. Do not ent	er the mod	e of dying	g, such as o	cardiac or	respiratory ar	rest,		Ap	proximate terval Between
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Division of Vital Records, P.O. Box	l or Att after d Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory	, office		28	If. Location (S City or Tow			r Rurai Ro	oute Number,
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	6 - 5 -) andi			1	0509	29		10	8/23	3/2005		
•	8,		30. Name and address of person who con	mpleted gause of death (Iter	n 23a) (Type.									
	10		Joy Mandarana L	ENISM.D. I	4065.	DIVE	sion	Stre	et-	Salisk	oun	, MD	218	804
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	Registr	ar	AUG 2 3 20	105 Mague	16 1	back	,							

State of Maryland / Department of Health and Mental Hygien 29043 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Roosevelt Williams 2:05 PM /Medical 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham P.G. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□F Months Hours Min 86 Director 214-12-0383 12-25-18 S.C Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show show **Funeral Director** P.G. MD. Yes 2 No New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is markad other than "natural", or itams 23a or other traumatic event, the Medical Examinat must be a 5908 Westbrook Terr. 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiena 12th U.S. Government U.S. Marshall's Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be item 27 is markad o should ba Grant Williams ၀ Aire Mathis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 784 19a. Informant's Name/Relationship (Type, Print) Gladys Williams/Wife 5908 Westbrook Terr. New Carrollton, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₹ **XX**Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Maryland Nat. Cem. 8/23/05 * 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Md. 22. Name and Address of Facility
The House of Williams Fun. Svc. 21. Signature of Funeral Service Licensee) ellens 814- Upshur Street, N.W. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIORESPIRATORY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DYSRYTHMIA. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit CORONARY BRTERY that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 ☐ Yes 2 ☐ No 3 Probably ∮ Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has funeral director, page 2 autopsy performed 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No by the f within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide fillad in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 18/05 M D0058290 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURCSHKUMAR WITATIUM 4203 QUEENSBURY RD. 12YATTSVILLE MY 20181 31. Date filed (Month, Day, Year) AUG 22 32 Registrar's Signature State 2005 Registrar

05-05638

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ammy We	asenforth _{For}	State of Maryland / Department of Health and Mental Hygiene	^
JD	1 - State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death	2

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	Physici /Medic		Decedent's Name (First, Middle, La Tammy		asenfo	orth					2. Date of Dear Month August	h		3. Time of Death 1247 P. M
	Examir		4a. Facility Name (If not institution, give Memorial Hospital	e street and nu	imber)		4b. City, Cumb		Location of nd	f Death			County of Death	-
i	Funeral Director		236-02-7030	ex □ M 2 ∏ F	7. Age (In yr:	s. last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day)	Year)		ace (State or Foreign try)
	n the Maryland r 28a-f ehow	irector	Usual Residence of Decedent 10a. State 10b. County WV Minera 10e. Street and Number	1		City, Town or Lo	ocation 10f. Zip	Code			1	0g, Citi	zen of What Coun	Od. Inside City Limits 1 XYes 2 No
250	be filed within 72 hours after death with the Maryland ital Hygliene death with the Maryland of other than "natural", or iteme 23a or 28a-f ehow event, Ira Medical Examinat must be notified at	by Funeral Director	96 Maryland 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dec	cedent Ever in orces? 2 No ive X	1				in? (Spe Puerto	city Yes or No- Rican, etc.)		SA 14. Race - America Black, White, e Specify: Whi	etc.
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ž v	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 le marke eny injury or other treumatic QDCB.		Rickey Weasen 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Condition 5 Other (Special	forth	State	96 N Place of Dispo	Maryl osition (Nar matory or o	and ne of ther plac	St.	Key	ser, V	IV 2	26726 cation - City or To	wn, State
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State Registrar

111 Penn Street, Baltimore Maryland 21201

		1	For State Registrar	State of Mar	yland	/ Depa	ertment of tificate o	Health of Death	and Mo		giene Reg. No.	2005	29045
		-	1. Decedent's Name (First, Middle, Last)	11.3						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic	al L	Lotta Ride							Augus		3 2005 County of Death	6:30 P
	Examin	er	4a. Facility Name (If not institution, give s Berlin Nursing &		tion) (+v	4b. City, Town		of Death			Worceste	r
	Funeral		5. Social Security Number 6. Sex	7. Age (st birthday)	If Under 1 Ye	ar If Unde		8. Date of Bir	th	9. Birtho	ace (State or Foreign
	Director		219-10-2900 ^{1□}	M 2DXF 8	32 -	Yrs.	Months Da	ys Hours	Min.	Dec. 9,	1922	Coun	<u> </u>
	put *		Usual Residence of Decedent 10a, State 10b. County	1	0c. City.	Town or Lo	cation					1	0d. Inside City Limits
	Aaryia f eho	ŏ	DE Sussex			orgeto							1≹jYes 2□No
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Lotta Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinal memult be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 X No. If Yes, Give Year or Dates:			Was Decedent f Yes, specify C 1 ☐ Yes 2 🖔			cify Yes or No Rican, etc.))- 1	14. Race - Americ Black, White, Specify: Whit	etc.
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980	iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland authorn of Health and Mental Hyglene. Terront: If item 27 Is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Macked Examinar must be notified at the macked of the traumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	No	13. Was Decilif Yes, sp		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)		14. Race - Amer Black, White Specify: WH	
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Baltimore,	Pages 1 nent of He int: If iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	XRemoval from State	20b. Place of cemeter	Disposition (Na y, crematory or	ame of other place	9)	Da	te	20c. Lo	cation - City or T	own, State
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Вох	The law requires that the death cert lie has been signed by the attending page 2 should be detached for use a	Physician/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnancy 2 Petal death	3 ⊟Ectopic p	oregnancy				2	3d. Date of deliv	,
	he at the at	sici	in the past 12 months?	4☐Pregnant at 9☐ Unknown		5 Other (s						Month	Day Year
P.0	that the de ed by the ded detached	Phy	9 Unknown			***				00- Did	-		4
ds,	ires ti signe d be d	by	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause give	in in Part I.			obacco u: Yes 2[the cause of death? bably 4 Unknown
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a										1 Yes	2 No		2□ No
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of	Phys	1: To	1 ☐ Yes 2 No 27. Manger of Death	1 Inpatie 28a. Date of Inju			OA 28c. Injury	4 U Nurs	_	o 5 □ Resid d. Describe I		Other (Speci	fy)
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_	dospite 4 hours Funerat ely fillec	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the best of the basis of and manner sta	examination and	death occurred Vor investigation	d at the tim n, in my op	e, date and inion, death	place, an	d due to the at the time,	cause(s) date and	and manner as s	stated. o the cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner sta	acod.	29	c. License	number		Т	29d. Date	signed (Month,	Day, Year)
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7	V		30. Name and address of person who					16	'		100	031 17	12003
			POWLTWT NADKARNT				ER DR	. RO	CKVIT	LE. M	D 208	350	

State

Registrar

31. Date filed (Month, Day, Year)

AUG 19 2005

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 29047 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death **Physician** ,205 12:05MM Elizabeth Viola Whyte /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges Doctor's Hopsital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | 1 1 - 2 0 - 1 9 0 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√2 F 103 577-20-2068 Yrs. Director Wash., D.C. Usual Residence of Decedent 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or items 23e or 28e-1 show other treumstic event, the Medical Examinar must be notified at , 1 ☐ Yes 2 ☑ No Director MD. P.G. Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4730 Ridgeline Terrace 20720 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ If Yes, Give Year or Dates: Specify: Black permit. Pages 1 and 2 should be filed within 72 hours
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural; , any injury or other treumatic event, in a Medical Example. 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Clerk Gov'T. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Mahoney Annie unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaTrice Andrews /neice 4730 Ridgeline Terr., Bowie MD., 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial 8/25/05 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD. 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility B.K. HENRY FUNERAL HOME 420 H Street NE., Wash., DC., 20002 , MO1178 Approximate
Interval Between
Onset and Death 23a. Part1. Enter the issease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☑No Division of Vital Records, P.O. detached 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☑ No 2 No of or Attending Physicien: after death. I Director: After this certification 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28 No 1_Inpatient 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pendina 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel or within 24 hours af To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B AMAN ND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

Charles D. William S Baltimore, Maryland 21215-0036

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DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29048 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 24 **Physician** 10:10 PM CHARLES DELMONT WILLIAMS 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Belca Me Year If Under 24 H/s. HARFORM ouen a KIVERSIDE 8. Date of Birth (Month, Day, 6/8/19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. **№** M 2 F Months Hours 68 Yrs. 543-34-4567 Director Oregon Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 X No Jarrettsville Director Harford MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Items 23a 2052 Cox Road 21084 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1958
1 Mayes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 No Specify Specify 3 Widowed 4 Divorced Year or Dates 1980 White "natural" 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Chemical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) United States Army 0 Warfare Instructor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Williams Fred Dorothy Lyon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type, Print) Barbara J. Williams/Wife item 27 P.O. Box 213 Jarrettsville, Maryland othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages Department of Important: If it any injury or o o * 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. 8/27/2005 Fallston, Maryland 21. Signature of Funeral Service Licen ee 22. Name and Address of Facility Jarrettsville, Maryland Son Funeral Home, P.A. Kurtz & 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician DIVATION disease or condition resulting in death) me /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9☐ Unknown à Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2☐No 3☐ Probably 4 ☐Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has autopsy performed? 1 Tyes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 20 NO Certification: To 1 Yes A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1_Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a Certifier 14 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) 32. Registrar's Signature State Registrar 2005

	•	State of Mary State Unpend Item 23a,27,28a-f Registrar 1. Decedent's Name (First, Middle, Last)		Timodic or		2. Date of Death		3. Time of Death
Physi /Med		Geneva Mae Yingling				August_	Day Year 22 2005	05:58 M
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	
X		Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	Westmin		8. Dale of Birth	Carroll C	holace (State or Foreign
Funera Directo		213-24-9296 1□M 21 F	77 Yrs.	Months Days		Dec. 17	, 1927 Ma	ry land
) pu		Usual Residence of Decedent 10a, State 10b, County 10	c. City, Town or L	ocation				10d. Inside City Limits
Maryle f eho	jo	Maryland Carroll		Jnion Bri	dae			1 _Y es 2 □ No
aryland 21215-0036 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. o marked other then "naturel", or iteme 23a or 28e-f ehow umatic event, the Medical Examiner must be notified at	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
ath wit		101 S. Lightner St.			1791		U.S.A	
er de:	Funeral	11. Marital Slatus 12. Was Decedent Ever Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🐧 No	r in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
036 urs aft	þ	3 Widowed 4 Divorced Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	hite
5-0 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done	during most of working	9	6b. Kind of Business/	Industry
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Aarylan 2 should be 1 and Mental 1 e marked of	5 B	Ellis S. Crushong	·		01ivi	a Metz		
Baltimore, Maryland 21215-0036 sernit. Peges I and 2 should be filed within 72 hours all bepartment of Heelih and Mania laygiene. mportant: if Item 27 is marked other then "naturel", or my injury or other treumatic event, the Medical Expansing injury or other treumatic event, the Medical Expansing injury or other treumatic event, the Medical Expansion		19a. Informant's Name/Relationship (Type, Print)		-	and Number or Rural		C-01	Zip Code)
1 and Health		Dennis L. Yingling/son 20a. Method of Disposition	20b. Place of Dispe	Watson osition (Name of	Da		MD 21791 0c. Location - City or	Town, State
Peges nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		matory or other pla s Luth.	Cem. 8/26/	2005 L	Jniontown,	MD
Baltimo		21. Signature of Funeral Service Licensee			ess of Facility Har	_		
0 8855		Catharine C. Margler	- 6	E. Broa	dway Uni	on Bridg	ge, MD 217	91
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dyi	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
Pnysicia /Medica		Immediate Cause (Final disease or condition resulting in death) Smoke inha		nd therma	al injury			10-111-0-2
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Division of Vital Records, P.O. Box 6876 after death certificate better death. The law requires that the death certificate bater death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the b	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p	Fetal death 3	⊒Ectopic pregnanc	y		23d. Date of deli	ivery Day Year
or the dear	ystci	1 ☐ Yes 2 No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	e of death 5{	Other (specify) _				
. P. thet t	y Ph	Part II. Other significant conditions contributing to death but no	ot resulting in the t	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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ecco law re as bea	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The law cete has page 2 s	Con					perform	ed? death?	2 No
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Of Of IPhys or this or this eral dir	2: 12	27. Manner of Death 1 Natural 5 Pending (Month, Day Ye	2 PR/Outpatie	nt 3 DOA	4 Nursing Hon	ne 5∐ Residen 8d. Describe how	ice 6 Other (Spec v injury occurred	cify)
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Divis lor Atte after de Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	At home, farm, st	reet, factory, office	2	Bf. Location (Stre City or Town,	state)101 S.	Lightner St.
Dittel cours at		Scene	u kanuladan dan	h	10	DITOH DE	rage, Ma	
Division of Vita to the Hospitel or Attending Physician: or the Funeral Birector: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier Certifying Physician: To the best of m (Check only one) Medical Examiner: On the basis of examiner and manner stated.	amination and/or in	ivestigation, in my	opinion, death occurre	d at the time, dat	te and place, and due	to the cause(s)
To th Within To th compl	₹	29b. Signature and title of certifier		29c. Licen:	se number	296	d. Date signed (Monti	h, Day, Year)
		Yanya Bow hall, mo		0.C	M.E.	A	ugust 22	2005
		30. Narpa and address of person who completed cause of death			D-1+4- · ·	M1	01 001	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's		Street,	Baltimore	, магута	nd 21201	
		AUG 2 6 2005	. K	hand .				
Regi	м	AUG & O COUJ ZURA	U Jr					

State of Maryland / Department of Health and Mental Hygiene 29050 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** September 5, 2005 8:45 Myrtle A. Adkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 26 Roaches Lane <u>Baltimore</u> Reisterstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Yrs. 92 Director 213-05-8049 April 23, 1913 Maryland Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 286-f show other traumatic event, the Maylical Examities must be mailfined at 1 Yes 2K No Director MDBaltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26 Roaches Lane 21136 U.S.A. death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours efter of and Mental Hygiene. Is marked other then "natural", or fter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 NWidowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Service Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Plein Henrietta Salff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other traum once. Vicki L. Almond Daughter 26 Roaches Lane Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Carroll Cremation Ser! 9/7/05 Hampstead, Maryland 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Maryland 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lad der disease or condition resulting in death) more /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ drease arten 1 Xes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe 2**X**No 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours of To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Karllar mo D16189 7/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. Charles St 4/615 TOWSON MD 2/20x KARKARMO EORGE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18,19a/per-mother 8877,13-11-08,14t/98/dk

	. "		1 - For State Registrar	CHACIRI	State of	Marylan		attment of a rtificate of	Realth and Death		Me rie No. 7	05	20051
			1. Decedent's Name	(First, Middle, Las	st)					2. Date of Dea	ith —	U 3	3. Time of Death
	Physici /Medic		Richard C	. Bradle	√					SEPT.	4, 200	5 Year	0028 A M
	Examin		4a. Facility Name (If 714 MORS			er)		4b. City, Town, OJARRET	or Location of Deat TSVILLE	h		y of Death FORD	
	Funeral		5. Social Security No			Age (In yrs.	last birthday)	If Under 1 Year			Year)	9. Birthp	lace (State or Foreign
ь	Director		378-92-95	45	_X M 2□ F		22 Yrs.	Months Days	Hours Min.	Dec. 8,		Flin	t, Michigan
	2		Usual Residence of			10- 01							0.1
	arylar thow	Ļ	10a. State	10b. County		Toc. City	y, Town or Lo	cation				1	0d. Inside City Limits 1 X Yes 2 No
	88-1	cto	MA	Midd	Lesex	Malo	len						
	or 2	Dir	10e. Street and Nun					10f. Zip Code			10g. Citizen of		
	death with the Maryland me 23a or 28a-f ehow croust be notified at	Funeral Director	79 Summit	Street	12. Was Decede	ent Consin II	C 112	0214			United		
	er de	nu	11. Marital Status	ed 2 Married	Armed Force	ac?		f Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Bla	ce - Americ ack, White,	
36	hours efter turel', or Ita	by	3 ☐ Widowed		If Yes, Give	□ N°2002 s: 2003	5	1☐Yes 2∑XNo	Specify:		Speci	⁄y: Whi≀	
21215-0036	ture at the	ed		15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occu			16b. Kind of E		
215	nin 72 In no	ple	(Speci	ify only highest gra	de completed) College (1-4	or 54)	(Give life.	kind of work done DO NOT use retire	during most of wo	rking			·
212	d within giene. In then	Completed	Elementary/5000	12	College (1-4	01 34)	Labo	rer			Constru	ıction	1
	e filed within al Hygiene. I other then "	Bec	17. Father's Name (First, Middle, Last)		1 -		1-1	18. Mother's Na	me (First, Middle,	Maiden Suma	me)	
/lar	ould be Mental Markad o	To	George D.	Fraser	Leona	rd Jose	eph Br	adley	Marjorie	Marie Reco	yno rmack		
Maryland	s 1 end 2 should be filed within 72 hours elter death with the Marylan if Heelth and Mental Hygiene. Item 27 is marked other than "neture!", or Iteme 23e or 28e-1 ehow other treumstic event, the Medical Exeminar must be notified at	•	19a. Informant's Na	me/Relationship (Type, Print)		19b. Maili	ng Address (Stree	t and Number or R	ural Route Numbe	r, City or Town	, State, Zip	Code)
Σ	end 2 selth n 27 I		Marjorie	C. Frase	/Mother				reet, Mal	den, MA_	02148		
ore	of He		20a. Method of Disp	osition Cremation 3	Demoval from St	20b. P	lace of Dispo emetery, crea	sition (Name of natory or other pla Admin.	ace)	Date	20c. Location	- City or To	own, State
Ē	Peg nent ent: I ury o			5 Other (Specifi		Nat	erans	Admin. Cemetery	9/8	7/05	Bourne,	Mass	sachusetts
Baltimore,	permit. Peges 1 end Depertment of Heelti Importent: If Item 27 eny Injury or other t		21. Signature of Fu	10.11	192	#cco	1 10		ess of Facility ZZIETO Fungton St.			4A 021	43
			23a. Part1. Enter the shock, or hear	ne disease, of com	plications that cau	sed the death	n. Do not en	er the mode of dy	ngton St. ing, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Finlal	Mo	Malie	tou	inid					Onset and Death
4	/Medical		resulting in death)		Due to (or	as a consequence	uence of):	10,000					
	Examiner		Sequentially list con	nditions	b								
	D =	ner	cause (Disease or	mediate riving	Due to (or	as a consul	serice of):						
	icate be executed physicien and s the burial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L		c								
, 00	se exe Sien a urial-	Ě	resulting in death) L	.45(Due to (or	as a consequ	uence of):						
68760,	icate be execu physicien and s the burial-tra	edical			d							-	-
			IF FEMALE:		23c. If yes, outco	me of pregna	nev				22.4.5		
Box	Batt attr	by Physician/M	23b. Was decedent in the past 12	months?	1☐Live birt	h 2 ∏ Fetal	death 3	Ectopic pregnance Other (specify)	су			ate of delive onth	Day Year
P.O.	e	ysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	JNo	9□ Unknow		Ja 5 C	g Carrot (apoony) _					
	ge g	ᇫ	Part II. Other signifi	icant conditions o	ontributing to dea	th but not res	ulting in the u	nderlying cause gi	iven in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
of Vital Records,	requires een sign nould be									101	es 2 No	3 ☐ Prob	ably 4 Unknown
Ö	> D to	Completed								24a. Was	an 24b.	Were auto	psy findings available
Re	The lavelete hes	E C								autop	med?	prior to col death? 1 🗀 es	npletion of cause of
tal	ician: Th certificete rector, pag	0	25. Was case refer	red to medical					26. Place of De	1 TYes ath (Check only o	2□No	1 LPT 85	2□ No
Ž		To B	examiner? 1 (X) Yes 2 □	No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3 DOA Ot	han	dome 5 ☐ Resid		her (Specif	AT SCENE
0	g Phys er this eral di		27. Manner of Death		28a. Date of (Month,		28b. Time o			28d. Describe h			
Division	ttending I deeth. ctor: Atter y the funer	atio	1 ☐ Natural 2 ☑ Accident	5 Pending investigation		- 07	0223		Yes 22No	PASSEM	an in a	AR R	ougven
<u>vis</u>	r Atte	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of	Injury - At ho	ome, farm, st	eet, factory, office		28f. Location (S City or Tow	treet and Num	ber or Rura	I Route Number,
۵	s ett	Certification:			5555	roon	-					ARRET	TSVILLE, HDR-
	To the Hespital or Attendi within 24 hours efter deeth. To the Funaral Director: A completely filled in by the fu	cal	29a. Certifier (Check only	1 Certifying Ph	ysician: To the b	est of my kno	wledge, deat	h occurred at the t	ime, date and place opinion, death occ	e, and due to the o	ause(s) and m	anner as s	lated.
	the H in 24 the F the F	Medical	one)		and manne	r stated.							
	To To	2	29b. Signature and	title of certifier	01. 0				Se number	-	29d. Date signe		
,			MOU	me It	elfrele	- m		0.	C.M.E		SEPT.	4, 2	005
6	50		30. Name and addre	ess of person who		of death (Item 1	1 23a) (Type,	Print) IN STREET	BALTIM	ORE MARVI	AND 21	201	
	/		31. Date filed (Mont	th Day Year)	1) DE 1	jistrar's Signa		DIRLINI	الملكلاللام				
	Sta Registr		5 52to mod (1910)	SEP 0 72	005	Aska a	K A	asoles					
					100	Andrew 9	-						

State of Maryland / Department of Health and Mental Hygiene 29052 1 - For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First_Middle, Last) 2. Date of Death **Physician** 55 AM ซ5 /Medical unty of Death Facility Name (If not institution, Examiner towar If Under 24 Hrs. Birthplace (State or Foreign Country) If Und Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exert insurant be notified at 1 Yes 2 No Director more 10g. Citizen of What Country? 10f. Zip Code or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Iten any injury or other traumatic evant the Market and any injury or other traumatic evant. 1 Never Married 2 Married Specify: Blace 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, nant's Name/Relationship rint) Willow 20c. Location 20b. Place of Disposition (Name of City or Town, State Method of Disposition Burial 2 Cremation 3 Removal from State ☐Donation 5 ☐ Other (Specify) 0000 21. Signature of Fameral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so shock, or heart failure. List only one cause on each line. as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PICENCE CA-ROIDVALCOUMR THEROCCLEROTIC Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physiclan/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) signed by the a ld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Tyes the Hospital or Attanding Physician: filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 1 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ◆ Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 1 🗖 Natural 5 Pending 1 ☐ Yes 2 ☑No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 🖃 🇲 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D6060 Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMOR 01-109 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9/ 2005 2:30 Alvin J. Bushy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Futurecare Cherrywood Reisterstown
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F 12/ Michigan Director 1919 <u>710-07-8002</u> 86 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Reisterstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? # 102 302 Cantata Court 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or ther any injury or other traumatic event. ☐Yes 2점No 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: by Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Montgomery Wards, Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Bushy Alice Desmaraif 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Cantata Court #102 Reisterstown MD 21136 Luella Bushy Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Nicolet Mem. Cardens Sept 12, 05 GreenBay, Wisconsin 21. Signatur of Funeral Solice Licensee 22. Name and Address of Facility 11824 Reisterstown Road once. Eline Funeral Home Reisterstown MD 21136 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause or Approximate Interval Between Onset and Death caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physiclan/Medlcal phys. as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant condition ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No Other: ဥ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie death (Item 23a) (Type, Print) 30. Name and address no completed 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygieney 29054 For Stata Registrar Amend ITem #10a-f Per INF C850 TITE #14 1050 Compth Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Dav Year John Paul Bernard 31, /Medical August 2005 7:30 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Annapolitan Assisted Living Community Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∏M 2□F Months Director 59 455-72-9292 1946 Jan. 18, Connecticut Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow | 10d. Inside City Limits the Medical Examiner must be notified at Anne Arundel Director 1 ☐ Yes 2 🕅 No TX MD Annapolis Dallus 28a-1 Decoto 10e. Street and Number TH OLD Mill BOTTOM RD. 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 21401 75115 - United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be tiled within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Madical Exercised Once. Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: 3 ☐ Widowed 4 M Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8+ Contract Attorney Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Bernard <u>Clara Guglietti</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Jones Daughter 1728 Gemini Drive Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept. All Saints Cemetery 2005 New Haven, Connecticut 21. Signature of Toperal Septem Licens 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 18eas /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö 9☐ Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ∑Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Division of Vital 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 SNo 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide o the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print) Ofun Burnie MD21061 208 Sw 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** tember 5,2005 ARTHUR THOMAS BOEMMEL, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b_City, Town; or Location of Death Examiner altimore Maryland General BALTIMORE CITY If Under 24 Hrs. 5. Social Security Number 6. Sex (In yrs. last birthday if Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 7. Age Funeral Days Min. 1√3 M 2□ F Hours 219~18~8826 80 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23e or 28e-f show traumatic event, the Madical Example or must be inclined at Director 1 ☐ Yes 2√☐ No Baltimore Baltimore County Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 5706 Trumps Mill Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XM□Yes 2□No If Yes, Give Year or Dates: WW 11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2CXNo Specify: Specify þ 3 ☐ Widowed 4√2 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Repair Technician N/A Lucent Technologies 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) l and 2 should be fi fealth and Mental H Arthur Thomas Boemmel, Sr. Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Importent: If item 27 Is
eny injury or other trau Robert J. Boemmel (Son) 5706 Trumps Mill Rd. Baltimore, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State X XX Burial 2 Cremation 3 Removal from State 9~9~05 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 ass akn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause pro each line. Approximate Interval Between Onset and Death peumonia Immediate Cause (Final disease or condition resulting in death) Physician /Medical bother time Pulmonary Disease Examiner Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial P.O. Box 68760. Completed by Physician/Medical as use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No certificate 1 Yes 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2**X** No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours : To the Funerel | 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waryland 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 29056 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day /ear **Physician** August 26, 2005 Dolores C. Brooks 4:25 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 □ M 2 🕏 F Yrs. 215-30-3746 Director Dec 1, 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 √ Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2319 Monticello Road Completed by Funeral 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: black 3 ☐ Widowed 4 ☑ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 0 librarian assistant education traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be George Colvin Williams Ruth Elizabeth Coakley ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health ar Importent: if Item 27 is any injury or other traus Daneil Matthews/son 6402 Hanover Crossing Way Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 XDonation 5 Other (Specify) 21. Signature of Funeral Savice Licensee Ronald S. Wade Naty 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 212U1

23a. Part 1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) encephalopath. Physician /Medical Due to (or as a consequence of): weeks Examiner vasculitis dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 2 No 1 Tes : After this certifical funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ther (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a. Certifier To the Fune completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NGUST 26 LOS 30. Name and a mess of person who completed cause of death (Item 23a) (Type, Print)

AMON (MANGE, M) (GGO! N - Charles) 100 2120 DM NGLWON 54 Charles MA MANON 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 0 7 2005 Registrar

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - For State Registra 29057 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Richard Thomas Butanis Sr. September 4, 2005 8:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5106 Kenwood Avenue Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 GM 2 □ F Months Days Hours Mir 220-32-3117 70 Vrs Director 6/11/1935 Maine Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. ortant: If item 27 le marked other then "neturel", or items 23a or 28e-f ehow injury or other trenumatic event, the Mudical Exculping in any less and items are modified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5106 Kenwood Avenue 21206 Be Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jimmy Butanis Louise Kuras 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Butanis/Wife 5106 Kenwood Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. Parkwood Cemetery '4 Donation 5 Dother (Specify) 9/7/05 Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service License 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, o shock, or heart failure. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cormanyartery de /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Que to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 ⊡Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2/2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 2 Accident nerel Director: , filled in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifies Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **り**る1022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Acto MI) 7602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

			For State Registrar	State of M	arylanu /	Cei	rtificate of Deat	th	Reg.		29058
	A PAGE		Decedent's Name (First, Middle, La	ast)				1	2. Date of Death Month	Day Year	3. Time of Death
100	Physicia /Medic		Betty Faulkner Cr	owder				A	August 3		7:35 P ^M
	Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, or Location	on of Death		4c. County of Dear	th
		. e	Prince George's H				Cheverly	dor 14 Hrs		Prince G	
ţž.	Funeral			Sex 7. Ag 1 ☐ M 2XTF	e (In yrs. last bi	irthday) Yrs.	If Under 1 Year If Und Months Days Hour	rs Min.	B. Date of Birth (Month, Day, Yo	9. Bin Co	thplace (State or Foreign ountry)
15	Director		579-54-8387 Usual Residence of Decedent		/1				ian. 12,	1934 Nor	th Carolina
	yland Iow		10a. State 10b. County		10c. City, Tov	wn or Lo	eation				10d. Inside City Limits
	Mar B-1 sh	tor	D.C.		Washin	igto	n				1 M Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		10g	. Citizen of What Co	ountry?
	23a		5057 Bass Place,				200			nited Sta	
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🗓 No Spec	city:		Specify:	Black
9	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28s-f show he Modicel Examiner must be notified.	ted 1	15. Decedent's E	ducation	16a	a. Dece	dent's Usual Occupation		16	b. Kind of Business	
215	hin 7.	Completed	(Specify only highest gi	rade completed) College (1-4or	5+)		kind of work done during n DO NOT use retired)		9	24 14 1	
2	filed withi Hygiene. Ither then	Con	11			Home	e Health Nurs			Medical	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28s-1 show other treumatic event, the Modical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las S.K. Leak	t)				otners Name (helma B	(First, Middle, Mai Barrett	den Sumame)	
Z	2 should be and Mental Is marked o	T ₀	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailir	ng Address (Street and Nur	mber or Rural	Route Number, C	ity or Town, State,	Zip Code)
	1 and 2 s Health ar em 27 ls		Marcella Leak/Sis	ter	2	.06	Jerome Street	t Winga	ite, NC	28174	
ore,	es 1 a of Hear I tem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3		20b. Place o	of Dispo	sition (Name of matory or other place)	Da	ite 20	c. Location - City or	Town, State
Ë	Pages nent of I ant: If Its ury or o		4 □Donation 5 □ Other (Spec		\perp Churc	h Co	matory or other place) OVE emetery	Sep 5	2005 V	Vingage,	NC
Baltimore,	permit. Pages Department of Importent: If I any injury or QUCE.		21. Signature of Funeral Service Ho	ensee Bosz	#CC032	1 22	Name and Address of Fa ighway 109, I ount Gilead,	North,	P.O. Box	tal Home 573 27306	
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	Physician		Immediate Caused Final disease or condition	FATAL	CARI	DIA	te Arry	thous			Onset and Death
	/Medical Examiner		resulting in death)	a. I	a consequence	of):		V			
h	LXamillei	_	Sequentially list conditions,	b. Due to (or as	a consequence	of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	o 01).					
Ć,	execun n and al-tra	Exar	that initiated events resulting in death) Last	Due to (or as	a consequence	e of):					
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	rtifica ng ph as th		IE EGNALE.								
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Re	The law te has age 2 s	mo							autopsy performe 1 Yes 2	d? prior to death?	completion of cause of
Vital	i cian: Th certificate rector, pag	e	25. Was case referred to medical				26. PI	lace of Death	(Check only one)		
of V	Physician: rthis certificated frall director, particular	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati		utpatier	nt 3 DOA Other: 4	Nursing Hom	e 5 Residenc	e 6 Other (Spe	ocify)
o Lo	ding P h. After t		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	lry Year) 28b.	Time o Injury	Work?		8d. Describe how	injury occurred	
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Div	after after Direct	ertil	4 Homicide determine	building, e	ic. (Specify)		con actory, omeo		City or Town, S		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Certification;			of examination a		h occurred at the time, date vestigation, in my opinion,				
	within To the	Me	29b. Signature and title of certifier	/			29c. License numb			Date signed (Mont	th, Day, Year)
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1			30. Name and address of person who DAVID JACC	completed cause of	300 /) (Туре,	tospital I	DR. C	heverc	4 MD	20785
	Sta Regista		31. Date filed (Month, Day, Year)	32 Gegist	rar's Signature	A	and I		,	/	

State of Maryland / Department of Health and Mental Hygiene 2005 2

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₹ 1 41	Dhuaiai		1. Decedent's Name (First, Middle, Las	st)					2. Date of D Month		ay Year	3. Time of Death
	Physici /Medio		Neal David Crowder	•					Septem		01,2005	11:00 P.M
	Examir	ier	4a. Fecility Name (If not institution, give			4b. Cit	, Town, o	r Location of De	ath	4	c. County of Deatl	
Ţ.			Gilchrist Hospice		to a de trade	-t1 If I Ind	er 1 Year	OWSON	m a =		Baltimor	
	Funeral Director		5. Social Security Number 6. S 216-42-0387	ex 7. Age (In yrs. ☑M 2□F	V.	Months		Hours Mi		av. Yea	r) Co	nplace (State or Foreign untry) yland
	۵ > ۵		Usual Residence of Decedent 10a. State 10b. County	100 0	T	or Location						
	shov	5										10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	the N	Director	Maryland Baltimo	re County Pl	noeni		- 0-1-			10- (Na	
	with	늅	17 Fairwood View	Corret		101. 2	ip Code	101			Citizen of What Cor	
	deeth with the Maryland ms 23a or 28a-f show Linual be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S.	13. Was Dec		131 Ispanic Origin?	(Specify Yes or N		ited Sta	
0	witter of the state of the stat	Fun	1 ☐ Never Married 2X Married	Armed Forces? 1 X Yes 2 ☐ No					(Specify Yes or Nerto Rican, etc.)		Black, White	
2-003	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: Vietr	nam	1 🗆 Yes	2 No	Specify:			Specify: W	hite
ה ה	2 should be filed within 72 hours after deeth with the Marylan and Manial Hygiene statems 23a or 28a-1 show te marked other than "natural", or items 23a or 28a-1 show aumatic event. It a Marical Examinat must be inclifted at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. D	ecedent's Us Give kind of w	ual Occup	ation during most of w	vorkina	16b.	Kind of Business/I	ndustry
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4	iled w Hygiei her ti	S	17. Father's Name (First, Middle, Last)	04	Sel	f Empl	oyed		c Designe		Crowder	Design
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	hould d Me mark matic	မ	19a. Informant's Name/Relationship (Type Print) (Wife)	19h A	Azilina Addres	e (Street			har Cih	or Town, State, Z	in Code)
<u> </u>			Mrs. Sally Grinne								Marylano	
Ď	to and Health tem 27 other to		20a. Method of Disposition	20b. F	Place of D	isposition (Na crematory or	ame of	rew Cour	Date		Location - City or 1	
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	ospit hours unere		29a Certifier Certifying Ph (Check only 2 Medical Exam	ysician: To the hest of my kno	wledge, c	leath oggurre	at the tim	nu, data and pla	ac, and due to the	nausc(s) and warmer as t	stated.
	To the Hospital or Attending Physician: The lawithin 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	fedical	Olle)	niner: On the basis of examina and manner stated.	mon and/				curred at the time	, date a	nd place, and due	to the cause(s)
	Zon Kith	Σ	29b. Signature and tyle of certifier	0			c. Licens			_	ate signed (Month,	Day, Year)
	V		rucar	In		1)57	5303		Sep	Kirber	Lus
	10		30. Name and address of person who	completed cause of death (Iter	n 23a) (Ty	/pe, Print)	770		0212	ðu.		
	Sta	to	31. Date liled (Month, Day, Year)	32. Registrar's Signa	iture	2 37	100	م رساله	700	1		
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			1- State Unpend Item		nd/Depa per me	artment of F	lealth an Death ^{ta}			
	Physici	an	Decedent's Name (First, Middle, Las	(1)	a 1 :			2. Date of Deat Month	Day Yea	
	/Media	al	Brandon	aterat and number	Calc	lwell 4b. City, Town, o	r Logotion of F		ER 4,2005 4c. County of D	12:45P. M
	Examin	er	4a. Facility Name (If not institution, give 458 GREEN STREET	street and number)		HAVRE DE			HARFORD	gatri
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24			Birthplace (State or Foreign Country)
	Director		213-98-8846 1. Usual Residence of Decedent	X M 2□F	23 Yrs.	Months Days	Hours	Hrs. 8. Date of Birth (Month, Day) September	30°, 1981	MD.
	yland Iow		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Mar.	to	MD. Harford		Havre I	De Grace				1 ☐ Yes 2 X No
	or 28)ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	ath w	rai	458 Green Street			21078			USA	
	er de	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin an, Mexican, P	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	within 72 hours after death with the Maryland ane. then "natural", or iteme 23a or 28a-f ehow the Madical Exerciter must be notified at	by Funeral Director	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 M No tf Yes, Give Year or Dates:		1 ☐ Yes 2 🌠 No	Specify:		Specify:Wh	nite
21215-0036	2 hou	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation	,	16b. Kind of Busine	
215	e. en "n Med	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of d)	f working		
2	ed wil	S	9 years		Med	chanic			Towing	
nd	tal H	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle, I	_	
3	J Mer Darke	ဠ	Merle Crouse 19a, Informant's Name/Relationship	Sura Orian	105 14-15	- Add (Chron		ah Ann Hlop		7: 0: 4:
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or iteme 23a or 28a-f ehow entry for other traumatic event, the Madical Examinar must be notified at ODGe.		Deborah Caldwell	mother				or Rural Route Number avre De Gra		
ē,	Heal Heal tem		20a. Method of Disposition			osition (Name of matory or other place			20c. Location - City	
Baltimore,	Page ent of nt: If I		1 Donation 5 ☐ Other (Specification 5 ☐ Other	memoval from State		n Cemeter			Dundalk,	MD.
alti	mit. partmoorta		21. Signature of Funeral Service Licen					l Home Of D		
0	Depa Impo eny i		Unthony	(on nelly	ν	7110 Soll	ers Poi	int Road, D	oundalk, MI	
	Pnysician	(f. 1)	23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the one cause on each line. Methadone Ir			ng, such as ca	rdiac or respiratory arro	est,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		L 1011				
	Examiner	L	Sequentially list conditions, I any, leading to immediate	b	atrana a taggi					
	led sit	Examiner	Cause (Disease or injury	Due to (or as a nonse	quence oty:					
_,	execu and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):			· · · · · · · · · · · · · · · · · · ·		
760,	ate be executed hysician and the burial-transit	caiE		d						
89	tificat ig phy as the		_							
Вох	leath certificat attending phy I for use as th	N/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1□Live birth 2□Fe		Ectopic pregnance	,		23d. Date of	
Ю. Ш	s that the death ned by the atter a detached for a	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (specify)			Month	Day Year
<u>α</u>	that the ed by detac	Ph	Part II. Other significant conditions c	ontributing to death but not re	sulting in the u	nderlying cause giv	ren in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
rds	w requires I been signe should be							1 □ Ye	es 2 No 3	Probably 4 Unknown
Vital Records,	2 2 2	Completed						24a. Was a	y prior	autopsy findings available g-completion of cause of
<u>=</u>	ysician: The is certificate hadinector, page							1 Yes	ned? death 2 No 1 Y	
Ξ	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 □XYes 2 □ No	Hospital:	3500	- 3 DOA O#		Death Check only on		COTINE
ō	Physical dispersion of this serial dispersion of the serial dispersion	 - 4	27. Manner of Death	28a Date of Injury	☐ ER/Outpatier 28b. Time o	IL SU DOA	4 Nursi	ing Home 5 Reside	ow injury occurred	oecity) SUEINE unk
<u>.</u>	Attending r death.	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Found 12:45		rk? Yes 2 X ∏No	,		dine
Division of	if or Attend after death Director: ,	Certification:	3 ☐ Suicide 6X Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number or	Rural Route Number, reen St.
۵	urs afte rel Dir	Se		Found in ho	use			Havre De	Grace, Md	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Madical Examone)	ysician: To the best of my kr ninar: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the til vestigation, in my c	me, date and popinion, death	place, and due to the ca occurred at the time, d	ause(s) and manner ate and place, and c	as stated. ue to the cause(s)
	Vithii To 11	×	29b. Signature and title of certifier	1,		29c. Licens		2	9d. Date signed (Mo	onth, Day, Year)
	01		Mayanto 1)	he Shull	IW	0.0	.M.E.	S	SEPTEMBER	5,2005
-10	18		30. Name and addr ss of person to	1/2-	ет 23а) (Туре,		STRFF	T BALTIMORE	E MARVI ANT	21201
1	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature //a			· National	TRIVITIBILIT	, 2.201
	Registr		SEP 0 7	2005 \ Cases	J. J.	porte				

State of Maryland / Department of Health and Mental Hygiene 2005 29061 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FRANKLIN D. CLARK, JR. **Physician** Month Year 1:30 Рм Sept. 2005 /Medical 4b. City, Town, or Location of Death Timonium 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Stella Maris Hospice **Baltimore** 5. Social Security Number 214-96-5736 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 5, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 1966 39 Yrs Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f ehow the Medical Examiner must be notified at Maryland| Anne Arundel Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 167 West Meadow Road 21225 USA death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 1 No f Yes, Give A rear or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 No ģ Specify: White 3 □Widowed 4 ☑ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then College (1-4or 5+) Elementary/Secondary (0-12) Auto Mechanic Auto Body Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 2 should be f and Mental h Franklin D. Clark, Sr. Louise Philomena Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or othar traum once. (Sister) 167 West Meadow Rd., Baltimore, Maryland Judy Ann Vance 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept.10,2005 Fort Seybert, W. Va. Rexrode Family Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Juneral Service Licensee Kevin E. Ecker Name and Address of Facility McCully-Polyniak Funeral Home, P. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the attershould be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has autopsy performed? Yes 2 2 No certificata 1 ☐ Yes 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 ☐ Yes 2 😿 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: completely filled in by the 3 Suicide 6 □Could not be Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1143721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2005

SEPTEMBER

FRANKLIN CLARK

			1- State of Maryland / State of Maryland /	Depa Cer	rtment of H	ealth and M Death		iene200	5 29062
÷		19	Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death
	Physici /Medic		Virginia Lee		Colem	an	09	06 200	5 4:00 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Stella Maris Towson		4b. City, Town, or TOWSO	Location of Death		4c. County of De Balti	
*24	Funeral Director		5. Social Security Number 245-20-7974 6. Sex 1 □ M 2 ☒ F 87	virthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	lirthplace (State or Foreign Country) NC
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Lo	ation				10d. Inside City Limits
	Maryli -f sho	tor	MD NA Balt						XXYes 2□No
	th the or 28a e rou	lrec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	
	ath wi	rai	3000 Towanda Ave #415			1215		U.S.A	
36	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or Items 23e or 28e-f show event, I're Medical Exertinar must be rediffed at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 3 Nover Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 3 Nover Nover in U.S.	11	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 XNo	spanic Origin? (Spi n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W Specify:	nerican Indian, hite, etc. Black
2-0	72 hou natura	ted	15. Decedent's Education 16 (Specify only highest grade completed)	a. Deced	ent's Usual Occupa	ation furing most of work	ina	16b. Kind of Busine	
21215-0036	within iene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8th grade na	life. L	NOT use retired,)	9	Priv	ate
	should be filed withir nd Mental Hygiene. marked other than imatic event, Ina Mi	Be Co	17. Father's Name (First, Middle, Last)		J	18. Mother's Name	(First, Middle, I		
Maryland	2 should be and Mental I is marked o	To B	Edward Coleman			Bessie	Philli	ps	
Mar								r, City or Town, State	. Zip Code) 21215
	of Health of Health (item 27 I		Nicole Gatewood-Great-Niece 20a. Method of Disposition 20b. Place	of Dispos	sition (Name of			20c. Location - City	
altimore,	Pages nent of P nnt: If ite ury or of		DEBurial 2 Cremation 3 Linemoval from State	odla	natory`or other place AWN	9/10	/05	Baltimor	e Co, Md
Balti	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Licensee	Ma	Name and Address	I West	Balti	more, Md	21215
2 × 2	a An A		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.						Approximate Interval Between
12.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) CONGESTIVE 1		r failure				Onset and Death
1.9	Examiner		Due to (or as a consequence	e of):					
验.	7 =	ner	Sequentially list conditions, fairly, leading to immediate cause. Enter Underlying	e of):					
	ecuted and -transi	Examiner	Tarry, leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)	0.06%					
8760,	cate be executed physicien and the burial-transit	aiE	Due to (or as a consequence	e oi).					
9	ifficate g phys as the	edicai	d		-				
Вох	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea	th 3□	Ectopic pregnancy			23d. Date of o	delivery Day Year
0.	that the dealed by the all	ysici	1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 ☐ Unknown	5 🗆	Other (specify)			Widner	Day Tour
<u>α</u>	res that t igned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ords	w require: been sig should b						1 □ Y€	es 2□No 3□	Probably 4 Nunknown
Records,	e law re has be je 2 sh	Completed					24a. Was a autops	sy prior t	autopsy findings available o completion of cause of
alF								X □No 1□Y	es 2 No
Vital	Physician: this certifical ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🏋 No Hospitat: 1 ☐ Inpatient 2 ☐ ER/C	Dutpatien	3 □ DOA Othe	26. Place of Deatler: 4 □ Nursing Ho		ence 6 X Other (S	Decify) HOSPICE
n of	ding Phy h. After thi funeral (n: T		. Time of	28c. Injury Work	at		ow injury occurred	HOST FOE
Siol	Attanding r death. ector: After y the fune	catic	2 Accident investigation			Yes 2□No			
Division	2 # 5 =	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	tarm, stre	eet, factory, office		281. Location (SI City or Town		Rural Route Number,
_	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only onl) Medical Examiner: On the basis of examination and manner stated.	ge, death and/or inv	occurred at the tim restigation, in my op	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
	//	1			D43	3725		9/6	105
6	1		30. Name and address of person who completed cause of death (Item 23a				IM 0100		
(6)3	Sta	ite	DR. TARIQ MAHMOOD 2300 DULANEY 31. Date filed (Month, Day, Year) 32. Registrar's Signature			'IMONIUM,	MD 2109	5	
	Regist		SEP 0 7 2005 Reduces A.	Son.					

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 1 per phy G847 9-7-05 tas Reg. No. Reg. No. 2005 1. Decedent's Name (First, Middle, Last) Arline E. Drake 2. Date of Death Month Se PT Year **Physician** 1.45 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOW ARD HOWARD COUNTY GENERAL HOSPICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You May 19, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** , 1941 Shreveport, LA Months Days Hours Min 1 □ M 2 🛛 F 434.58.9133 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mantal Hyglene.
The state of Health and Med the Hyglene of the state Md Howard Columbia 1 ☐ Yes 2 ☑ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8381 Tamar Drive. Apt 515 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ashley Elton Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greg Drake- Son 8381 Tamar Drive.Apt 515 Columbia, Md 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury of once. Columbia Mem. Pk 9-6-05 Clarkesville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, Md 21045 ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DNEUMONIA Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SEPSIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner BUEEDINS Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit GASTRO INTESTINAL that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š TROILE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 🗌 Yes 2/2 No 1 Tes 2/2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tyes 2 7No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deatl To the Funerel Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0056940 KTTENDING 2005 SEPT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREE T 21217 MO 522 DOLPITIN BALLINONE MO TANDINDA 31. Date filed (Month, Day, Year) 32 Registrar's Signature mark State Registrar SEP 0 7 2005 To the said

				For Stete Registrer			State of	f Marylaı		artmen e <i>rtificat</i>				lental Hy	/gier Reg. I	2005	5 6	29064
	. 🖑	Physici	ån	Decedent's Name EDW		A.	DULO							2. Date of D Month SEPT.	[2005	r	3. Time of Death 2:05 p M
		/Medic		4a. Facility Name (I				nber)		4b. City,	Town, or	Location	of Death	SEPI.		4c. County of De		2:05 p [™]
		- 0		STELLA	MAR	S H	OSPIC:	E			MON:					BALTIN		
		Funeral Director		5. Social Security N 214-20- Usual Residence of	1601	6. Sex	M 2□F	7. Age (In yrs		Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D JUNE	inth bay, Yea	9. B 1924 V	irthplac Country /IR(e (State or Foreign) GINIA
	land	MO TE		10a. State	10b. Coun	ty		10c. C	ity, Town or	Location							10d.	Inside City Limits
	Man	a-f eh	ctor	MD.	N	'A			BAL	TIMOR	E							¹X Yes 2□No
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	d 21215-0036 filed within 72 hours after death with the Maryland	iene. rthen "natural", or items 23a or 28a-f ehow the Madical Examinar must be notified at	by Funeral Director	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		erried	Armed For	rces? 2 □ No		If Yes, spec				ecify Yes or N Rican, etc.)	0-	Black, Wh	nite, etc	
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	ylan ould be	e 5 €	To B	N/A								MAR	Y DU	II ₁ O				
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1	, Mi	of Health and Mer item 27 ie marke other traumatic		ANTHONY)/ sc	ON					ANE,				MARYLAN		
	more			20a. Method of Disp 1 Burial 2	Cremation		moval from	State	Place of Disposery, cr	ematory or o	ther place			ate		Location · City of		
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at	rtmer rtant njury		4 ☐ Donation 21. Signature of Fu				SF	ACRED						_			MARYLAN
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	Ph	ysician		Immediate Cause i	Final	or only on		ONARY A	RTERY	DISEA	SE						Or	nset and Death
	23.	Medical kaminer		resulting in death)		(a.		or as a conse	-									
		Admin'er	10	Sequentially list co	nditions,	b.		or as a conse	quence of):								-	
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	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed.	by the attending phatached for use as th	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ☐ No	23	1 Live b	come of pregrinth 2 Pet ant at time of	al death 3	□Ectopic pr						23d. Date of d Month	elivery	у Үөаг
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	ion oding	ith. :: Afte e fune	atior	1 Natural 2 Accident	5 Pend inve	ding stigation	(Mont	h, Day Year)	Injury	М	8c. Injury Work 1 □ \	<br Yes 2□				,,		
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	e Hospi	e Funer letely fill	Medical	29a. Certifier (Check only one)	1 Certify 2 Medic	ing Physial Examin	er: On the ba	best of my kn asis of examin ner stated.	owledge, de ation and/or	ath occurred investigation	at the tim in my op	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time	cause , date a	(s) and manner and place, and di	as state	d. e cause(s)
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Division of Vital Records, P.O. Box 68760.

			For State Registrar		State of	Marylan		artment of rtificate o			lental Hy	/giene Reg. No.		5 5	0065
	Physici	on	1. Decedent's Nam								2. Date of D	eath Day	Yea	3.4	moof bald J
	Physicia /Medic				GELIS, S						Sep.		200	1-	· W A W
	Examin	er	4a. Facility Name (GENESIS		ive street and numb CARE LOCH			4b. City, Tow LOC	H RAV	EN		4c.	BALTIN	MORE	
	Funeral Director		5. Social Security N 213-07-2	2549	Sex 7 1☐YM 2☐F	Age (In yrs. 91	last birthday) Yrs.	If Under 1 Ye Months Da		der 24 Hrs. rs Min.	8. Date of Bi (Month, D OCT • 2	$\overset{\text{irth}}{2}$, $\overset{\text{rth}}{1}$	913 9. B	irthplace (: Country)	State or Foreign ITALY
	and		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						10d. in:	side City Limits
	Maryli f eho	ro	MD.	N	I/A		BALT	IMORE						1 [XYes 2 □ No
	r 28a	Director	10e. Street and Nu	ımper				10f. Zip Coo	le			10g. Citi	izen of What (Country?	
	th wit	alD	427 WEST	THAM WAY					212	24		1	U.S.A.		
3	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menthel Hygiene. item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, Itte Medical Examinational be notified a	by Funeral	11. Marital Status 1 ☐ Never Mari	ried 2□ Married	12. Was Deced Armed Ford 1 [3]Yes 2 If Yes, Give Year or Dat	es? 2 □ No		Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☐X	Suban, Mex	cican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - An Black, Wh Specify:		
	2 hou	ted	(600	15. Decedent's I	Education	·	16a. Dece	dent's Usual Oc	cupation	most of work	ina	16b. K	ind of Busines	s/Industry	
<u>,</u>	thin 7	Completed	Elementary/Sec	ondary (0-12)	College (1-	4or 5+)	life.	kind of work do DO NOT use re	tired)	most of work	ing			2015	
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	Pages 1 and 2 iment of Health a tant: If item 27 is jury or other trau			•	□Removal from S	tate	emetery, crei	osition (Name of matory or other CEMETE	place)	9/3/	05		cation - City of		
la	permit. Pages Department of Important: If ii any injury or o		21. Signature of F	ynera/Service Lic	ensee			2. Name and Ad 6224 EA							
		-6	shock, or he	art failure. List onl	mplications that car y one cause on ea	ch line.	h. Do not ent	ter the mode of						Appro	oximate val Between at and Death
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5	ding h	tlon:	27. Manner of Dea	atn 5 □ Pending investigati		njury , Day Year)	28b. Time o Injury		njury at Work? 1 □ Yes 2		28d. Describe	now injur	y occurred		
	I or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page	Certification:	2 Accident 3 Suicide 4 Homicide	6 ☐ Could not	be 28e. Place of	of Injury - At he g, etc. (Specif	ome, farm, str y)	reet, factory, off			28f. Location City or To	(Street an own, State		Rural Rout	e Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one)		Physician: To the taminer: On the base	sis of examina									ause(s)
	To the within To the compl	Me	29b. Signature and	d little of certifier	tond.	ing P	hysix	29c. Lic	ense numb	64z		29d. Dat Se /	te signed (Mo.	nth, Day, Y	'ear)
ĺ	UP		30. Name and add	dress of person who	o completed cause	of doth (Item	0 Ch /	Print)	B10	103	V3 \$	0/7	timon.	02	1259
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

KEITH MICHAEL FLEM Amend item#17,18,19a, perFH, G847,9/20/05 TT State of Maryland / Department of Health and Mental Hygiene 2005 UNK 05-06068 R.I 29066 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year September 5, 2005 **Physician** em. 1:38 a. M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Slasman Road @ Blacksteer Drive Finksburg Carroll County 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex / 1 ☑ M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Year) Yrs. 173-70-7020 Pennsylvania Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No NJCamder Funeral Director 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 Yes 20 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/egcondary (0-12) arpente Construction Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Ma permit. Pages 1 and 2 should be Deportment of Heelih and Mental Important: If Item 27 is marked any injury or other traumatic averages. tarold Sr. ဥ SIIIC 19a. Informant's Name/Relationship (Type Print) 19b. Mailin, Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crandmothe NJ Baltimore, 20b. Place of Disposition (Name of Date 20a. Methed of Disposition 20c. Locatin - City or Town, State cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Ficility Evans Funeral 21. Signature of Funeral Service Licenses 8800 Harford rd. Park 21234 Approximate Interval Between Onset and Death 23a. Pard. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MULTIPLE INNRIES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ettending physicien and for use as the burial-transit Hospital or Atlanding Physician: The lew requires thet the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown After this certificate hes been signed funeral director, pege 2 should be de-Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ es 2 ☐ No 24a. Was an autopsy performed? 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ${}_4\square$ Nursing Home ${}_5\square$ Residence ${}_6$ Nother (Specify) At SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 1 XYes 2 □ No this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending PASSENGER 04 CHIL 915105 1 ☐ Yes 2 SNo 1:30 AM 24 hours efter death. Funeral Director: A 2 Accident investigation COLLISION 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) INRC BURG, HU 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide SLASHANROL BLACKSTEER RD ROAD Medical 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Penn Street Baltimore, Maryland 21201 RUBIO HD ANA 31. Date filed (Month, Day, Year) SEP 0 7 2005 32 Registrar's Signature State A SANS Registrar

				State	of Mary	land / Dep <i>Ce</i>	artment of I rtificate of	Health and Death	Mental Hy	giene 20	05	2906	7
	Physici /Medio		Decedent's Name (First, Middle SAR)		SY	FORBUS			2. Date of De Month Sept.	5, 20	Year 105	3. Time of Death 2:25 A.M.	
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	Funeral Director		Alice Byrd Taw 5. Social Security Number 215–38–0627	es Nursin 6. Sex 1□M 2☐F	7. Age (Ir	e 1 yrs. last birthday 155 Yrs.	If Under 1 Year Months Days		s. 8. Date of Bir	th y, Year)		ace (State or Foreig	n
	D		Usual Residence of Decedent		1	c. City, Town or L	anting.		1202		-		_
	danyla f shov	ō	Maryland Some		10	c. Oily, Town of L	Crisfie	1d				d. Inside City Limits 1 X Yes 2 ☐ No	
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020	urs after de el', or items	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	If Yes. C	Forces? 2	r in U,S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Blac	e - America ck, White, e v: Whi	itc.	
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2	12 sho h and is me raum		19a. Informent's Name/Relation John G. Forbus				ing Address <i>(Street</i> V. Main S				State, Zip	Code)	
υ Σ	f Healt tem 27		20a. Method of Disposition		Date	20c. Location -		vn, State	_				
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2	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours elected sail. To the Funeurs elected at this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 289. Plac	ce of Injury - ding, etc. (S	At home, farm, si pecify)	reet, factory, office	28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural	Route Number,		
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a _e	Examin	er	Saint Joseph M			4b. City, Town, o	-	V S O TI		40.00	Balt:		
	Funeral		5. Social Security Number 6. Sex		birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8	Date of Birth (Month, Day	. Yearl	9. Birth	place (State or	Foreign
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	/land		10a. State 10b. County	10c. City, To	wn or Lo	ecation						10d. Inside Cit	y Limits
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	a 23a		1603 Timberline C	Ourt 12. Was Decedent Ever in U.S.	12	2128		inn /Consider			ed Star		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importment: If term 27 is marked other then "natural", or itema 23a or 28a-f ehow any injury or other treumatic event, the Medical Exatural intrinsit be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Amed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🏋 No	Specify:	Puerto Ric	an, etc.)		. Race - Amer Black, White pecity:		
0500-C	2 hou satura	ted	15. Decedent's Educ	eation 16	a. Dece	dent's Usual Occup	ation			16b. Kind	of Business/li		
7	ithin 7 ie.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most d)	of working					
7	tygien ther th		12	8 A	gric	ulture	Specia		First, Middle.		ricultu	ıre	
and	2 should be filed w n and Mental Hygie Is marked other ti reumatic event, It.	To Be	17. Father's Name (First, Middle, Last) Emmons	Blaine Fairchil	d			,	ebecca	_	umame)		
ar Z	should Mand Mand Mand Mand Mand Mand Mand Man	F	19a. Informant's Name/Relationship (Typ	pe, Print) 19	9b. Mailir	ng Address (Street					own, State, Zi	p Code)	
Ž	and 2 salth s n 27 ls		Mr. Sung Yul Kim	(step-son) 9	07 E	. Semina	ry Ave	nue,	Towsor	n, MD	21286	5	
ore	ges 1 of He		20a. Method of Disposition TV□ Burial 2 □ Cremation 3 □ Re		of Dispo tery, crer	sition (Name of matory or other place	(e)	Date	9	20c. Loca	tion - City or T	own, Slate	
Saumor	t. Pag rtmen rtant: rjury		Ty Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)								onium,		093
ח	Depared Depare		21. Signature of Fundal Service License	Brian		Name and Address Chisholm							у, Р.
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only on	ations that caused lhe death. Do e cause on each line.	o not ent	er the mode of dyin	ig, such as d	ardiac or r	espiratory arr	rest,		Approximate Interval Betw Onset and D	/een
5 m	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	INTRA CRANIA		EMORRHA	GE				1	WEEK	
10	Examiner		f	Due Io (or as a consequence	e of):								
	n =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):								
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last										
000,	cate be executed physicien and the burial-transit	al E		Due to (or as a consequence	e or):								
00	ificate g phys as the	edical	d										
Š	th cert endin	iclan/Me	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea	th 3	Ectopic pregnancy	,			230	d. Date of deliv	,	
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	ysici	in the pasl 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown		Other (specify)					Month	Day Y	өа <i>г</i>
ŗ.	that the objustment of the object of the objustment of the object of the o	/ Physi	Part II. Other significant conditions con	tributing to death but not resulting	in the u	nderlying cause give	en in Part I.		23e. Did tol	bacco use	contribute to	the cause of de	ath?
Spins	quires an sign uld be	ed by							1 🗆 Ye	es 2X	No 3□Pro	bably 4 □Ui	nknown
))	law re as bee 2 sho	Completed							24a. Was a		24b. Were aut	opsy findings a	vailable
<u> </u>	The yate his page	Com							perfore		death?	ompletion of ca 2□ No	120 01
	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	ospital:		100			check only on				
5	Phys r this ral dir	. To	1 ☐ Yes 2 ☑ No	1 K Inpatient 2 EH/C	Outpatien . Time of	t 3 DOA Oth	4 🗆 1901		5 Reside		Other (Speci	fy)	
200	nding th. :: Afte	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Injury	Wor	k? Yes 2□N		Dogonbo n	ow anjury c	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
2	r Atter	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eel, factory, office		28f	Location (St City or Town	treet and h	Number or Rur	a <i>l Route Numb</i>	ΘΓ,
2	oltal o urs aft oral Di												
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1∑ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death and/or in	n occurred at the time vestigation, in my o	ne, date and pinion, dealt	place, and occurred	due to the cat the time, d	ause(s) an late and pl	d manner as s ace, and due t	stated. o the cause(s)	
	To t	M	29b. Signature and title of certifier			29c. License	e number		2	9d. Date s	signed (Month,	_	
	NY		1				254			G	15/0	7	
C)		30. Name and address of person who cou	npleted cause of death (Item 23a	(Type,	Print)	grang a serie from a		PN 5 25	1 845	م المعلى ومعي الم		
	Sta	te	31. Date filed (Month, Day, Year)	76.21 OSLE 32. Registrar's Signature	K D	KIVE, T	UMPU	A" ME	RK A L'EIL	AD S:	1204		
	Registr		SEP 0 7 200	15 Alexand St.		340							

	du.	·	For State Registrar	State of Maryland / Department of Health an Certificate of Death	id Mental Hygier Reg. 1	711115 7411KU
	Physicia	an	1. Decedent's Name (First, Middle, Las	st)	2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	e street and number) 4b. City, Town, or Location of D	AUGUS 1	4c. County of Death
	Examin	er	Upper Cherapeck	e Modical Center Bel air		Harford
	Funeral Director		5. \$bcjal Security Number 6. S 217 · 141 · 1888 1		Hrs. 8. Date of Birth Min. (Month, Day, Yea	
*	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	4 3	10d. fnside City Limits
	Maryl e-f sho	tor	MD HARFOR	D FOREST HILL	T4. 18.	1 □Yes 2 ☑No
	vith the	Dire	10e. Street and Number	10f. Zip Code	~10g. (Citizen of What Country?
	ns 23e	Funeral Olrector	1826 COSNER	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or No-	14. Race - American Indian,
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28e-f show or other treumatic svent, the Medical Examinar rivel by Ivalify of a continuation of the medical Examinar rivel for a continuation or other treumatic svent, the Medical Examinar rivel for a continuation or other treumatic system.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: If Yes, specify Cuban, Mexican, F 1 ☐ Yes 2 ☑ No Specify:	uerto Rican, etc.)	Black, White, etc. Specify: WHITE
21215-0036	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (Give kind of work done during most of life. DO NOT use retired)	working 16b.	Kind of Business/Industry
212	od within giene. er then "	Comp	Elementary/Secondary (0-12)	College (1-40r5+) ELECTRICAL TECHNA	T	FENSE CONTRACTOR
	be filed ntal Hygin of other svent, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's	Name (First, Middle, Maid	en Sumame)
Maryland	2 should be and Mental Is marked of eumatic sv	2	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	or Rural Route Number. Cit	y or Town, State, Zip Code)
	1 and 2 s Health ar em 27 ls	,	JOSEPHINE GET	TIER, WIFE 1826 COSNER RD	FOREST H	1111 MD 21050
Baltimore,	jes 1 a of He If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or Town, State
tim	it. Pages rtment of rtent: If it njury or o		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licer	EVAS FINTER CHAPL	14	CHARL BLAR
Ba	permit. Pages 1 Department of H Importent: If ite any injury or ot once.	V) V	Signature of Fullera Service Liter	Moizzo 3 NEWPORT	DR. FORE	EST HILL, MD 21050
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		2	Approximate Interval Between Onset and Death
	Pnysician /Medical	6 B	Immediate Cause (Final disease or condition resulting in death)	. Suldwal henra to	THE	Onset and Death
	Examiner			Due to (or as a consequence of):		
	p tig	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence or).		
	xecute and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		
68760,	ificate be executed g physician and as the burial-transit	edical E		d		
	** D) 61		IF FEMALE:	C20 If you guttoms of programs		
.O. Box	The law requires that the death cert lite has been signed by the attending bage 2 should be detached for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown		23d. Date of delivery Month Day Year
<u>α</u>	res that the igned by be detact	by Pł	Part If. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death?
ord	w require been si should b	ted	thouse rep	reck facture		2 No 3 Probably 4 Unknown
of Vital Records,		Completed		/	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vita	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 1 1 1 Yes 2 □ No		Death (Check only one)	
	g Physer this leral di	1	27. Manner of Death	Hospital: 1 Nnpatient 2 FeVOutpatient 3 DOA Other: 4 Nursia	ng Home 5 Residence 28d. Describe how in	
Division	endin eath. or: Att	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	1 NU6VST 27 2V 5 1/4/ AM 1 1 Yes 28 No	A FALL	AT HOME
ΣÏ	or Att	ertifi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate) FIRST HILL MV 2/050
_	To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral or	Medical Co		ysician: To the best of my knowledge, death occurred at the time, date and pinner: On the basis of examination and/or investigation, in my opinion, death and manner stated.		(s) and manner as stated.
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. E	Date signed (Month, Day, Year)
	\		Bernoul 1.	Ushn MD, Dove DC0/4206	de 1	Tencles 6,2005
	Q		30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	VE BAETO	M 21272
	Sta		31. Date filed (Month, Day, Year) SEP 0 7 20	32 Registrar's Signature	r and	
	Registr	ar	3L! U 1 20	ON VINENT NO. WARREN		

	an	1. Decedent's Name (First, Middle,	Last)		GUI	014/	1 1 1			2. Date of De	Da		Year	12:00
/Medic		4a. Facility Name (If not institution,	give street and nu	ımber)	GUI			Location (SEPTE		. County o		12.00
Examin	er	HARBOR HOS	-		R	1		1410						
Funeral			6. Sex	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	th1-7	-194	9. Birthpl Count	ace (State or F
Director		022-30-2811	1 □ M 2 1 F	6	4 Yrs.	Montrio	Days	110013		Jan. 1	, 19	41 1	Massa	chuset
W #		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10	Od. Inside City I
-faho	tor	Maryland Anne A	rundel	Seve	erna P	ark								1 ☐ Yes 2
r 28a	Directo	10e. Street and Number	I diluci	Devi	criia r	10f. Zip	Code				10g. Cit	izen of W	hat Count	try?
it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23s or 28s-f show or other traumatic avant. It s Mccical Examinat must be notified at	alD	3 Cedar Point Ro	ad			211	46				USA			
"natural", or itams	Funeral	11. Marital Status	Armed Fo		.S. 13.	Was Deced	dent of Hi cify Cuba	ispanic Ori In, Mexicar	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.))-		- America k, White, e	
, or l	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes If Yes, Gi Year or D	ive		1 🗆 Yes	2[X No	Specify:				Specify:	Whit	
atura cal E		15. Decedent's	s Education		16a. Dece	edent's Usua	al Occupa	ation			16b. K	ind of Bus	siness/ind	
Mcd."n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College ((Give	kind of wo DO NOT us	rk done d se retired	during mos 1)	t of worki	ng				,
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Men	2	Frederick Reed								Marco				
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of Health a itam 27 i r other tra		Peter Gudwin/son 20a. Method of Disposition		20b. F	240 W Place of Disponentery, cre-	aver1	y P1	ace N		ork. N mber			10014 City or Tov	
Department of It Important: If its any injury or of once.		1 Burial 2 XCremation 3			emetery, cre Arund				_	mber				yland
ortan injur	i	21. Signature of Funeral/Service C		/				-						
Impo any ir		> Beverly L	Helt	to MOI						n Serv				
	-				4.) 1 D	everr	у ш.	песк	LULL	e. F.A		arksy	viile	, MD 2
	-	23a. Part 1. Enter the disease, or c	complications that	caused the deat		ter the mod	le of dying				rrest,			Approximate
veician		shock, or heart failure. List o	nly one cause on e	each line.	h. Do not en			g, such as	cardiac o		rrest,			Onset and Dea
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			. For	State of Maryland	/ Department of I		•	_	29071
			1 - Stata Registrar		Certificate of			2 U U J eg. No.	23011
	Physici	an	1. Decedent's Name (First, Middle, La	LOUIS	GEHL.		2. Date of Deat Month	Day Year	3. Time of Death G 30 A M
	/Medic Examin		4a. Facility Name (If not institution, give			or Location of Deatl	<u> </u>	4c. County of Deat	
				ABILITATIONS E		ARE BE	ALTIMOR	I NI	A
	Funeral Director		5. Social Security Number 6. S 212-26-4996 Usual Residence of Decedent	ex 7. Age (In yrs. last	t birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9. Birtl	pplace (State or Foreign untry)
	yland how		10a. State 10b. County		own or Location	•			10d. Inside City Limits
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	ours after death with the Maryland ral', or itams 23a or 28a-f show Examinat must be notified at	Completed by Funeral Director	10e. Street and Number 2515 W.E.	JTWORTH RA	10f. Zip Code	21234	1	Og. Citizen of What Co	A
	r death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Porces?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
20	urs afte	by Fi	Never Married 2 Married 3 Widowed 4 Divorced	1 Pres 2 No U S Tryes, Give Year or Dates: NAV	1 ☐ Yes 2 ☐ No	Specify:		Specify: L	uhite
3-003e	within 72 hours after death w ene. than "natural", or itams 23a the Madical Examiner must b	eted	15. Decedent's E. (Specify only highest gra	ducation	6a. Decedent's Usual Occup (Give kind of work done	during most of wor	rking	16b. Kind of Business/I	ndustry
7	within ene. than "	ompi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	nd) .		PAPER.	
שב	e filed al Hyg othar vant,	Be C	17. Father's Name (First, Middle, Last,		(1300)	18. Mother's Nan	ne (First, Middle, M	Maiden Surname)	
<u>ya</u>	tould by Menta	오	ALEXANDER	GRHL				: orusKA	
20	nd 2 sh Ith and 27 Is m		19a. Informant's Name/Relationship (ALCXANDRA	4. GehL	19b. Mailing Address (Street 2515 Went			· ·	
ore,	es 1 an of Heall f itam 2 r other		20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐	20b. Place	e of Disposition (Name of etery, crematory or other pla		Date	20c. Location - City or	
Банттоге	nit. Page bartment o fortant: If injury or		*4 □ Donation 5 □ Other (Specif	n) More	eland Cem	. 17/-	7/05	Balta M	٥.
g	Depar Impo any ir		21. Signature of Funeral Service Licer	tello	HARTICH P	Siller 5	TellA FV	NERAL HOM. NO 21234	(CHT).
	10 5		23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. I one cause on each line.					Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		TIC LUN	G CAN	VCER	TO BONE	Onset and Death
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ς, Τ	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditions of	ontributing to death but not resultin	ng in the underlying cause gr	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
cora	w require been si should I						1 🗆 Ye	es 2 No 3 Pro	bably 4 Unknown
Lec	e lav has je 2	ompleted					24a. Was ai autops perforn	v prior to c	opsy findings available ompletion of cause of
VII	sician: Th certificate rector, pag	C	25. Was case referred to medical			26. Place of Dea	1 ☐ Yes 2 ath (Check only on	.,	2∐ No
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ISION	ding Ph th. Alter th funeral	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	tb. Time of 28c, Injury Wo	ryat rk?]Yes 2 □ No	28d. Describe ho	w injury occurred	
DIVISI	tha Hospital or Attanding hin 24 hours after death. tha Funaral Diractor: Alter mpletely lilled in by the funer	ertification:	3 Suicide 6 Could not b 4 Homicide determined			_	28f. Location (Sti City or Town	reet and Number or Ru n, State)	ral Route Number,
	To tha Hospital or within 24 hours aft To tha Funaral Dii completely lilled in	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowle- niner: On the basis of examination and manner stated.	dge, death occurred at the ti a and/or investigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To tha within To tha comple	Me	29b. Signature and title of certifier	Hand.	29c. Licens			9d. Date signed (Month	
4	20		30. Name and address of person who	- bouston	CMDD2 Ba) (Type, Print) H RAVEN E	4045	8 0	14-03-	2005
	U		SHER A HASHA	11 3900 LOCI	4 RAVEN E	BLVD BA	ALTIMON	REMO 2	1218
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature	have				

				1- For State of Marylan	d / Dep		lealth and M	ental Hyg	giene Reg. No. 2005	5 29072
		Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
		/Medic	al	John E. Gamrod 4a. Facility Name (If not institution, give street and number)		4h Cihi Tourn ai	r Location of Death	August	22, 2005 4c. County of Dear	9:50 PMM
7		Examin	er	Baltimore-Washington Medical (Center		Burnie		Anne Arui	
7		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir 1, 1926 P	hplace (State or Foreign buntry) ennsylvania
3		Director		201-14-7495 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Yrs.	WOITIS Days	Tiours Will.	April I	1, 1926 P	enńsylvania
0		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or L	ocation				10d. Inside City Limits
10		Mary P-f sh	tor	MD Anne Arundel Pa	asaden	a				1 □ Yes 2 ☑ Wo
	,	filed within 72 hours after death with the Maryland Hygiene utter than "natural", or Items 23a or 28a-1 show part, the Madical Evantinat nat Le nufilled at	Funeral Director	10e. Street and Number 8200 Meehling Road		10f. Zip Code 21122			10g. Citizen of What Co USA	ountry?
		tems	uner	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Ď	36	irs afte	by Fi	1 ☐ Never Married 2 █ Married 1	II	1 ☐ Yes 2 ☐XNo	Specify:		Specify:	White
imro	21215-0036	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	Industry
3	21	ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			during most of worki	ng		
3	121	iled w lygier ther th	Cor	12 17. Father's Name (First, Middle, Last)	Stat	ionery Er	1gineer 18. Mother's Name	(First Middle	Hotel	
	and	d be f ental h ked of	To Be	Charles Frederick Gamrod			Nannie		waden Suname)	
J	Maryland	shoul ind Me s mark umati	F	19a. Informant's Name/Relationship (Type, Print)			and Number or Rura	I Route Numbe	ar, City or Town, State,	Zip Code)
		and 2 salth a n 27 is		Louise Gamrod - Spouse	_		ng Road I		a, MD 2112	2
	ore	tges 1 nt of He : If iter or oth		1 23 Bullat 2 Clemation 3 Linearioval note State		osition (Name of matory or other place		Date	20c. Location - City or	
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a may rigury or other traumatic event, the Medical Evaprimer must Lance.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses		ers Cemete 2. Name and Addre	ss of Facility Henney		Carnegie	, FA
	ñ	Der Per Per Per Per Per Per Per Per Per P		Maren 12000d D		524 Wash	nington Av	runeral 7e. Cai	ноте rnegie, PA	15106
•		Physician /Medical Examiner	er	23a. Part 1. Enter the disease of complications that caused the deal shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying	juence of):	iter the mode of dyin		or respiratory ar		Approximate Interval Between Onset and Death
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	ta	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Place of Death		21	2010
	of V	Physic this ce al dire	2	1 Yes 2 No Hospital: 1 Inpatient 2		ont 3□ DOA Oth	4 14013119110		dence 6 Other (Spe	cify)
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		To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kni (Check only one) Medicel Examiner: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
		To the within To the comp	M	29b. Signature and title of certifier	- 1	29c. Licens			29d. Date signed (Mon	
	,			, and sue	, au	(2)	024285		August 31,	2005
	(13)		30. Name and address of person who completed cause of death (Itel Charles E. Wiles III MD Balti	more-V	Vashingtor	n Medical	Center	Glen Burni	e, MD
		Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrates Sign		A collection				

			For 1_ State	State of Marylan	d / Depa	artment of H	Health and N	lental Hyd	giene_	
			State Registrer 1. Decedent's Name (First, Middle, Last)		Ce	rtificate of	Death	2. Date of Dea	Reg. No.20	
	Physici		Christine D. Ga	rroll Clif	ton			Month	Day	Year 3. Time of Death
	/Medio		4a. Facility Name (If not institution, give st.		COII	4b. City, Town, o	or Location of Death	08/26	4c. County o	10:23 A ^M
	LXaiiii		Somerford Place			Annapo				Arunde1
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	2	Birthplace (State or Foreign Country)
Ш	Director		238-32-2496	77	Yrs.	Line Line Sayo		(Month, Day 10/23	/1927	NC
land	Mo M		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
Man	2 3	to	MD Anne Art	ndel Pas	adena	1				1 ☐ Yes 2. No
th the	or 28,	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	hat Country?
-0036 hours after death with the Maryland	23a	rai	1352 Edna Road			21122			U.S.A	A •
er de	Items	Funerai		2. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H f Yes, specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, , White, etc.
)36 Irs aft	o, l	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
2 Po C	atura	ted	15. Decedent's Educa	ation	16a. Dece	dent's Usuaf Occup	pation		16b. Kind of Bus	
.1215- within 72	9 PB PF	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) Colfege (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ing		.,
d 21	Hygien ther th ant, the	Cou	9		Mach	ine Ope	1		Kopper	
Puc E	aven	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sumame	9
Maryland 21215-0036	and Mental Hygiene. s marked other than "natural", or liems 23a or 28a-f show umatic avent, tre Marical Examinat must be notified at	²	Oscar Duncan 19a. Informant's Name/Relationship (Type	Print)	19h Mailir	a Address /Street	Sally W and Number or Run		City of Town C	7- 0- d-1
	ulth an 27 is r trau		Jerry Garrell /	Son						^{State, Zip Code)} 21146 Park, MD
5 g	of Hea fitem r othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place				City or Town, State
Pages	int: If		1 Magazial 2 Cremation 3 Report A Donation 5 Dother (Specify)	noval from State	-		,	29/05	Glen Br	arnie, MD
Baltimore,	Department of Health and Men Important: If item 27 is marke eny injury or other traumatic once.		21. Signature of Emeral Service Licensee		22	. Name and Addre	ss of Facility G.	J.Gonc	e Funer	al Home, PA
10 8	4440		Ther Son		1	69 Rivi	era Dri	ve, Pa	sadena,	MD 21122
	hysician Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one frimediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line. Due to (or as a consequence)	4 1	,	OVAYI			Approximate Interval Between Onset and Death
	xaminer			Due to (or as a consequ	Prot	xhlo	ovari	012		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq						
cuted	sician and burial-transit	Examiner	that initiated events							
7 60,	cian a		resulting in death) Last	Due to (or as a consequ	uence of):					
SA/Cate t	physic s the b	dicai	d.							
O. BOX 68760, he death certificate be executed	the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. tf yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	/		23d. Date Monti	,
J. tad	signed by the a be detached f		Part II. Other significant conditions contr	ibuting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
dS ures	n sign Ild be	Completed by	malignant pie	ural effu	sion	abd		7 1 TY		Probably 4 Unknown
ecords,	s been should	olete	carcinomatos	sis, ou	Imoi	mary G	mhali	24a. Was a	n 24b. We	ere autopsy findings available
교 한 한	age 2	ошь	Alabanand	0,000,000	11101	1419)	autops	med2 de	or to completion of cause of ath?
	rtifica ctor, p	Be C	25. Was case referred to medical	erre rom			26. Place of Death			Yes 2 No
Of V Physic	his ce I direc	To E	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	spital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	t 3 DOA Cth			4	(Specify) ASSISTED
	Viter ti		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho	ow injury occurred	Livina
DIVISION I or Attending	tor: A	icati	Accident investigation 3 Suicide 6 Could not be				Yes 2□No			Resident
	after of Direction by	Certification:	4 Homicide determined	28e. Place of fniury - At ho building, etc. (Specify	me, tarm, str	eet, factory, office		28f. Location (St City or Town	treet and Number n, State)	or Rural Route Number
DIVISION Of VITA To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) Certifying Physic Certifying Phys	cian: To the best of my known: On the basis of examinat and manner stated.	wledge, death ion and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the cand at the time, d	ause(s) and mann ate and place, an	ner as stated. d due to the cause(s)
To	To tl	Σ	29b. Signature and title of certifier	-		29c. Licens	e number	2	9d. Date signed ((Month, Day, Year)
	1		om	0		D	41950		8/26	1/05
17	12		3 Name and address of person who com	pleted cause of death (Item	23a),(Type	Printy D. Co.	Thomas	#24	400	21108
(()	-0-		31. Date filed (Month, Day, Year)	32. Refistrar's Signat	OU/ N	- TOURS	MAGIN	oy 1	welles	IVITIE MD
	Sta Registr		SEP 0 7 20	201	B D	and I	,	/		

5965		riease i	Oteta of Manuford			-	-	
	-	For State	State of Maryland	Certificate of		mai nygien Reg. N	2000	29074
		Registrar 1. Decedent's Name First, Middle, Last)	0			2. Date of Death		3. Time of Death
Physic /Med		("ARLA	D. GARDA	IER	5	September ^D	^a 1, 2005	1249 А м
Exami		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, o	or Location of Death	4	c. County of Death	
d		Johns Hopkins Hos	pital	Baltimo		B. Date of Birth	9 Right	lace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 10	M 2 F 7. Age (In yrs. last	Yrs. Months Days	Hours Min.	Month Day Yea	965 MA	RV LAND
ש		Usual Residence of Decedent						
arylar •how	-	10a. State 10b. County	10c. City, 1	own or Location			1	0d. Inside City Limits 1
the Mi	ecto	10e, Street and Number		ATIMORE 101. Zip Code		10a. C	Citizen of What Coun	itry?
3a or	Funeral Director		LTIMORE ST.		21231		U.S.A	ł.
death	nera		2. Was Decedent Eyer in U.S. Armed Forces?	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
36 s after	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ Y No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No			Specify: BL	ACK
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. The marked other then "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar hourst be notified.	ed b	15. Decedent's Educ	cation 1	6a. Decedent's Usual Occu	pation	16b.	Kind of Business/Inc	dustry
215	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give kind of work done life, DO NOT use retire		14	INICON	100
d 212 filed with Hygiene other the	S		4	SERVICE	HGEN 18. Mother's Name	7	INSURM	vce
and libe fil ntal H ed ott	Be	17. Father's Name (First, Middle, Last)	1. JOHNSON			ICIA C	SASKINA	<u>C</u>
IOCE, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinational be notified at	2	19a. Informant's Name/Relationship (Ty)		19b. Mailing Address (Stree			or Town, State, Zip	Code)
and 2 : and 2 : ealth ar m 27 !e		WILLIAM F. CORN	ISH II (SON) I	705 E. BA	HTIMORE S.	t.#1 B	ATIMORE,	MD 21231
of He rother		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	com	e of Disposition (Name of etery, crematory or other pla		,	Location - City or To	
Z gent		4 □ Donation 5 □ Other (Specify)	ARBU		ERY 9.7.	05 AR	surus, Ma	RYLAND WERAL HM
Baltimore, permit. Pages 1 a Department of Hee Important: If Hem eny Injury or othe		21. Signature of Funeral Service License	Area a	22. Name and Addr	AK KOA		uct, luc	
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. I	Do not enter the mode of dy	ing, such as cardiac or		-0KOJ 1000	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	SUBARACHNO	IN WEHORD	HAGE			Onset and Death
/Medica		resulting in death)	Due to (or as a consequen	ice of):				
Examine		Sequentially list conditions,	Due to for as a consequent	12 - 1 - 1 - 1	VEURYSM			
√ pe u u u u u u u u u u u u u u u u u u	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Day to for an a control of	ned ory.				
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IS, P.O. BOX 68' res that the death certificat igned by the attending phy be detached for use as th	by Physician/Medi	IF FEMALE:	30. If yer, outcome of pregnance	v			and Date of deliver	
BO)	lan/	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3 Ectopic pregnance	у		23d. Date of delive Month	ery Day Year
P.O. hat the de	nysic	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	9☐ Unknown					
Records, P.O The lew requires that the ete hes been signed by the page 2 should be detached.	y Pi	Part II. Other significant conditions cor	ntributing to death but not resulting	ng in the underlying cause g	ven in Part I.	23e. Did tobaco	o use contribute to t	
cords w require been sig						1 🗆 Yes	2 □ No 3 □ Prot	bably 4 Munknown
lew r	Completed					24a. Was an autopsy performed?	prior to co	ppsy findings available impletion of cause of
Vital Rec lician: The lew certificete hes rector, page 2 a						1 N Yes 2 □ 1		2 No
of Vita Physician: this certific ral director,	Be	25. Was case referred to medical examiner? 1 X Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient 3□ DOA O	26. Place of Death		6 ☐Other (Specil	6/1
Physer this eral di	n: To	27. Manner of Death		Bb. Time of 28c. Inju		8d. Describe how in		y)
Vision Attending r death. ector: After	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day rear)		Yes 2 No			
Division of Vital Records, to Attending Physician: The lew requires effer death. Director: After this certificate has been signifin by the funeral director, page 2 should be	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	, 2	8f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
Dital of urs of aral Disable in illed ir	O	20 O VIII AD C Aibin Bhu	rigina. To the best of our knowled	and an all and a state of the s	time date and place a	nd due to the source	v(s) and manner as a	wated
Division of To the Hospital or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☑ Medical Exami one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	auge, death occurred at the nand/or investigation, in my	opinion, death occurre	ed at the time, date a	and place, and due to	o the cause(s)
To the I within 2 To the Complet	₩ W	29b. Signature and title of certifier		29c. Licer	nse number	29d. I	Date signed (Month,	Day, Year)
		> aust		0.C	M.E.	Sep	tember 1,	2005
ın		30. Name and address of person who co			D. 1	. M1	- 1 01 001	
10		31. Date filed (Month, Day, Year)		1 Penn Street	, baltimor	e, Maryla	III ZIZUI	
S Regis	tate trar		005 Magasar A	& Spell				
DHMH 17 Rev 1	-	VIII VIC	SAN THE PROPERTY OF					

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Elsie M. Grube September 6, 2005 10:35am /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2419 Gillis Road Mt. Airv Carroll 8. Date of Birth (Month, Day, Year) Sep. 27, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 MD 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 □ XF Months Days Min. 58 Yrs. Director 218-46-9714 1946 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f ehow r than "natural", or iteme 23a or 28e-f ehov the Modical Experiment nust be notified at 1 ☐ Yes 2 🗓 No MD Completed by Funeral Director Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2419 Gillis Road 21771 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours efter 1 ☐ Yes 2**Y** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing / Drapery Seamstress treumatic event. permit. Peges 1 end 2 should be file Depertment of Health and Mental Hy importent: if item 27 is marked othru any hijury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank W. Grube, Sr. Alverta Sanders P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles A. Ludwig, III (Son) 1618 Packard Drive Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 9/10/05 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Duano Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC NON SMALL CELL CARCINOMA **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pulmonary embolism 1 Yes 2 No 3 Probably 4 Unknown Acute RENAL PAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy NON IMMUNOLOGIC TRANSPOSION PRATETION performed? Yes 2 No 1 Yes 2 \ No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 2 Natural 2 Accident 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation nours efter death. Inerei Director: Afi filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours eft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier D31660 091061 Jalu. My In 2005 namas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS GAL M WESTMINSTER MARLIAND 291 STOWER AVENUR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 5

		•	= State Registrer	Cer	rtificate of Death	Re	g. No.	29076
	Physicia	ın	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year er 2, 2005	3. Time of Death 11:45 PM
	/Medic	al	Robert Harry Harrell Jr. 4a, Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	Septemb	4c. County of Death	
	Examin	er	6513 Westview Lane		Lanham		Prince Geo	rge's
	Funeral		5. Social Security Number 6. Sex 7. Age	ə (İn yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb 12,	Year) 9. Birth	place (State or Foreign ntry)
	Director		301-28-9446 ¹X м 2□F	71 Yrs.		Feb 12,	1934 Ohio	
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Manyli f sho	JO.	Maryland Prince George's	Lanham				1 ☐ Yes 2 No
	1 the 1 28a	rec	10e. Street and Number	<u> </u>	10f. Zip Code	10	g. Citizen of What Cou	ntry?
	230 o	ai D	6513 Westview Lane		20706	U	SA	
	ems :	Funerai Director	11. Marital Status 12. Was Decedent E	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 五 Yes 2 ☐ N 1 ☐ Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:		1 ☐ Yes 2X No Specify:		Specify: Blac	k
Ş	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or Items 23e or 28e-f show is marked other than "naturel", or Items 20e or 28e-f show eumatic event, Item Mariland II.		15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/îr	
215	nin 72 in "na Madis	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life.	kind of work done during most of work DO NOT use retired)	ing		
212	d with giene er the	Com	4	Sales			Advertising	5
2	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam Leota Re			
<u>\Z</u>	Men Marke Marke	70	Robert Harry Harrell Sr.	10h Maili	ng Address (Street and Number or Rus			in Code)
Maryland 21215-0036	d2st thanc t7 is n treun		19a. Informant's Name/Relationship (Type, Print) Michael T. Harrell/son		B West Rd. #2023 H			p 0000)
<u>6</u>	s 1 an f Heal item 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	elliber	20c. Location - City or T	own, State
Ë	Pages nent of I ent: If its ury or o		1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		el Crematory 6,	2005	Odenton, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e -f show amy injury or other treumatic event, Item Marited Examiner must be rutilized at once.		21. Signature of Funeral Service Licensee	GO GO	2. Name and Address of Facility oing Home Crematio	n Servic	e P.O. Box	784
			23a. Part1. Enter the disease, or complications that caused	the death. Do not ent	everly L. Heckrott ter the mode of dying, such as cardiac	or respiratory arre	CIAIKSVIII (est,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each lin Immediate Cause (Final	static	COLOA CO	NCE	-	Onget and Death
	/Medical		disease or condition resulting in death) a	a consequence of):	CO TOP CO	170 (0	•	700
	Examiner		Sequentially list conditions.					-
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a nonsequence of):				
_	xecuti and al-tran	хап	that initiated events resulting in death) Last C	a consequence of):				
68760,	tificate be executed ig physician and as the burial-transit		d					
		fedicai			-			-
Вох	th cer tendir rr use	an/N	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth	2 Fetal death 3	□Ectopic pregnancy		23d. Date of deli-	very Day Year
О.	The law requires that the death cer ate has been signed by the attendir cage 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify)			
Δ.	that the	, Ph	Part II. Other significant conditions contributing to death b	out not resulting in the t	underlying cause given in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
Records,	uires sign	d by				1 □ Ye	es 2□No 3□Pro	bably 4 Unknown
CO	w requires been signal	ompieted				24a. Was a	n 24b. Were au	opsy findings available
Re	The lav	omp				autops perforr	ned? death?	ompletion of cause of 2□ No
Vital		e C	25. Was case referred to medical		26. Place of Dea	th (Check only on		
of V	S S D	To B	examiner? 1 ☐ Yes 2X No Hospital: 1 ☐ Inpatie				ence 6 Other (Spec	ify)
			27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Inju (Month, Da	ay Year) 28b. Time o	Work?	28d. Describe ho	ow injury occurred	
Sio	Attending r death. ector: Afte oy the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	iuny - At home farm st	M 1 ☐ Yes 2 ☐ No	28f. Location (St	treet and Number or Ru	ral Route Number,
Division		Certification:	4 Homicide determined 200, Flace of Injury	jury - At home, farm, st tc. <i>(Specify)</i>	riod, factory, office	City or Town	n, State)	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier (Check only one) 1 XCertifying Physician: To the best of the best only one) 2 Medical Examines: On the basis of and manner st	of examination and/or in	ath occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Ivithin 24	Mec	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month	n, Day, Year)
	- s - o		V H/W law	- mo	060 3752	j s	September 6	, 2005
ì	[W/	~	30. Name an 1 d less of person who completed cause of c	death (Item 23a) (Type	Print)		. ^	20749
Y	17/		Rough C. Wheeler		ercaptile Land	Lang	o Mi)	20/1/
	St. Regist	ate	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	Anack &			

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			1 - For State Registrar	State of Mai	ylanu / L		nt of Health and te of Death	мена пу	Reg. No 20	OE	20077
			Registrar Decedent's Name (First, Middle, La	st)	-	Certifica	ile of Death	2. Date of De		UU	3. Time of Death
	Physici		Roy Lincoln	, .				Month Septen	Day	Year	215 PM
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. Cit	y, Town, or Location of Dea		4c. County	OOS of Death	2131
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	Funeral		5. Social Security Number 6. S	ex 7. Age	In yrs. last bil	thday) If Und Month	er 1 Year If Under 24 Hr	8. Date of Bi	rth av Yearl		ace (State or Foreign
	Director		249-20-2712	M 2□ F	78	Yrs.	S Days Hours Will	8. Date of Bi	27	PORTI	Caroling
	pue A		Usual Residence of Decedent 10a. State 10b. County		I0c. City, Tow	n or Location	-			10	Od. Inside City Limits
	Aaryli Peho	ō	Mr Bri) ·	A4 A A A				1 ☐ Yes 2 📉 No
	28e-1	ect	10e. Street and Number	more			MORC Lip Code		10g. Citizen of W	Vhat Count	
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	s within 72 hours after death with the Maryland liene. I then "naturel", or items 23a or 28e-f ehow The Medical Examinat must be motified at	Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Dec	sedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or N	o- 14. Race	- America	
٥	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Tyes 2 No If Yes, Give			22 No Specify:	no Hican, etc.)		k, White, e	itc.
5-0036	hours after lurel', or its	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		IL Tes	ZIE NO Specify:		Specify	Whi	te
Š	72 h "natu	Completed	15. Decedent's E (Specify only highest gra		16a	(Give kind of t	ual Occupation work done during most of w	orking	16b. Kind of Bu	siness/Ind	ustry
Z	within 72 ene. then "nai	m d	Elementary/Secondary (0-12)	College (1-4or 5+)	1	Liffe. DO NOT			10001	Tran	isters.
N O	Hygie other		17. Father's Name (First, Middle, Last		1	RUCK	DY IVE Y	ıme (First, Middle	a, Maiden Sumam		(2)(6)(2)
ğ	\$ 5 5 5	To Be	1 pland +	neris			Jenni	4.4	McDei	1	
>	s 1 end 2 should 1 Health and Men Item 27 ie merke other traumatic	F	19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Addre	ss (Street and Number or F		, Citt	State, Zip	Code)
<u>a</u>	end 2 ealth a n 27 ie		Ray L. Haccis	12.	7	371/	LWENdorer	Ave. B	AL THUNG	F	MD 21234
Baltimore,	ten item othe		20a. Method of Disposition		20b. Place o	f Disposition (A ry, crematory o	ame of	Date	20c. Location -	-	
Ē	Pages Iment of tant: If it jury or o		1		Porti	cod (emoto, 49-	7-05	PACTIVE	LOZE	MA
<u>a</u>	= = = = =		21. Signature of Funeral Service Lice	isee		22. Name	and Address of acility	HUTIMO	RE MA	212	34
מ	Depertment of the pertment of		Kunlelyh	- Sautolk	u	EVAN	S FUNSEMIC	·HAPCZ	,8800H	HRFC	120120
			23a. Part1. Enter the disease, /r com shock, or heart failure. Let only	plications that sused the	ne death. Do	not enter the m	ode of dying, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			humo	uelear Pal	SIA			Onset and Death
	/Medical		resulting in death)	Due to wras a				0			
	Examiner	L	Sequentially list conditions,	b							
	pg tis	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	SullSeylueNGE	ot).					
_	and I-tran	Examin	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):					
/60	ate be executed hysician and he burial-transit	caiE		2 22 (3) (2) 22 2		0.7.					
/89	phys phys s the			d							
×	if the death certifica by the attending ph tached for use as the	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date	e of deliver	TV.
. Box	death atte	ciai	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		3 ☐Ectopic 5 ☐ Other			Mor		Day Year
o.	the o	hysi	9 Unknown	9□ Unknown							
ري ح	iaw requires thet the as been signed by th 2 should be detache	by Physician/Med	Part II. Other significant conditions	contributing to death but	not resulting i	n the underlying	cause given in Part I.	23e. Did	tobacco use contr	ribute to the	e cause of death?
Records,	w require been sig should b		Meringiana	·				1 🗆	Yes 2□No	3 Proba	ably Dnknown
ပ္က	aw re	Completed	1	precumonia				24a. Was	s an 24b. V	Vere autop	sy findings available
	The tate had bage	E							ormled? d	leath?	piletion of cause of
Vital	ilan: ntifica ctor. p	BeC	25. Was case referred to medical examiner?				26. Place of De	eath (Check only			
o 	ding Physician: The lav n. After this certificate has funeral director. page 2	To	1 ☐ Yes 2 No	Hospital: 1 Inpatient		utpatient 3	OOA Other: 4 Jursing	Home 5□Res	idence 6 🗆 Othe	ar (Specify)
	ng Pl		27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurr	ed	
Division	eath.	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No				
<u>></u>	or At fter d Sirect in by	E	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	arm, street, fact	ory, office		(Street and Number own, State)	er or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune		202 Conffice	vericing. T- the bear of	man le		and as also a store and a store a store a store and a store a stor	1			
	24 ho Fun	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	nysician: To the best of niner: On the basis of e and manner state	xamination ar	e, death occum id/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the curred at the time	cause(s) and ma , date and place, a	nner as sta and due to	the cause(s)
	To the Hospital within 24 hours a To the Funeref I completely filled	Me	29b. Signature and title of gertifier				gc. License number		29d. Date signed	(Month, E	Day, Year)
	⊢ s ⊢ ō í		DAV. I				an Donce	22	50 -2 '		2222
	1700		30. Name and address of person who	completed cause of dea	ath (Item 23a)	(Type, Print)	~ 000574	<u></u>	completembe	~ 2	2005
	10,		Allidi Fembers	Cood Sanuri	tan Hudi	o, the Bat	- Bulleton # 20	3 Belton	ce MD =	2/239	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar	's Signature	A 40	-Buldry #30				
	Regist		SED 0 7 20	05	200	Elsonakia I	,				

		,	1 - For State Registrar	State of Mar	yland / Do	epartment of I Certificate of	Health and M Death	ental Hygie Reg	2005	29078
I	Physicia		1. Decedent's Name (First, Middle, Las Bernie		ilton			2. Date of Death Month September	Day Year 2005	3. Time of Death 9:43 AM
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give	street and number) OPU 1 THE STREET TO A	Cospita In yrd. last birth	day) If Under 1 Year	or Location of Death NOTE If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dea	
	D		212-60-6389 Usual Residence of Decedent					04 19	21	MD
	show	ž	10a. State 10b. County]	Oc. City, Town					10d. Inside City Limits 11√2 Yes 2 □ No
	the N 28a-i	rect	MD NA 10e. Street and Number		Balt:	10f. Zip Code		100	. Citizen of What Co	
	th with	al DI	7002 Park Heigh	ts Ave Ar	ot Ll	21	215		U.S.A	10"
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23a or 28a-1 show or other treumstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2X No If Yes, Give	er in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, te, etc.
9	2 hour etural	ed b	15. Decedent's Ed			Decedent's Usual Occur	pation	16	6b. Kind of Business	Black
21215-0036	within 7. ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		Give kind of work done life. DO NOT use retire	during most of workir nd)	ng		
	fited w Hygier other th		12th grade 17. Father's Name (First, Middle, Last)	na		Nurse As	sistant 18. Mother's Name		ursing	Home
Maryland	Mental Parked of atic eve	To Be	Johnnie Hilton				Annie B		iden Sumame)	
ary	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. /	Mailing Address (Street			City or Town, State, I	Zip Code)
	1 and 2 Health tem 27 i	1	Janie Hilton-Si							Md 21215
Baltimore,	ages 1 nt of H t; If ite / or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	riemoval mom State		Disposition (Name of crematory or other pla	1		c. Location - City or	
ıĦ	rtme rten		4 ☐ Donation 5 ☐ Other (Specify21. Signature of Funeral Service Licen.		King N	Memorial 22. Name and Addr March F/	Park 9/1	0/05 R	andalls	town, Md
ä	Dermi Depa Impo eny ir		> Whele Es	lmonde		March F/ 4300 Wab	H West ash Ave,	Baltim	ore, Md	21215
	*		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	ne death. Do no					Approximate Interval Between
	Prysician		Immediate Cause (Final disease or condition resulting in death)	. Abdomir	al Bles	ed				Onset and Death Hours
	/Medical Examiner		Todaling in doubly	Due to (or as a	1.	A				1
	40215	Jer	Sequentially list conditions, if any leading to immediat cause. Enter Underlying	b. Due to for as 1	consequence of	Disease				1 year
	fficate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Hepatitis	_C					Syears
68760,	be exi	al Ex	resuming in death) Last	Due*to (or as a	consequence of):			,	
687		edical		d						
.O. Box	w requires that the death certif been signed by the attending should be detached for use a:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year
<u>α</u>	es that gned b		Part II. Other significant conditions of				ven in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ord	requir een si hould	eted	Hypertension, Van	ricies, Cry	oglobuli	nemia		1 🗆 Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records,	The lay ate has page 2	Completed by						24a. Was an autopsy performe	prior to	Itopsy findings available completion of cause of
ΖË	sicien certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 XInpatient	2 ☐ ER/Outp	atient 3 DOA	26. Place of Death	-	0 Flores (0)	4.
1 of	g Phy er this neral d	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Tir	ne of 28c. inju	ry at 2	8d. Describe how	e 6 □Other (Specinjury occurred	city)
sior	ttendin death. ctor; All y the fur	atlo	1 Natural 5 Pending 2 Accident investigation	1911	- Tilly		Yes 2 □ No			
DİXİ	Hospitel or Attending Physicien: 24 hours after death. Funerel Director; After this certific tely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, fam (Specify)	n, street, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number.
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director; completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medicel Example 1 Medicel Exa	ysicien: To the best of iner: On the basis of e and manner state	xamination and/	death occurred at the ti or investigation, in my	me, date and place, a opinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
}	To the within 2 To the complet	M	29b. Signature and title of certifier	ones, mo		29c. Licens	- 000	0	Date signed (Monti	h, Day, Year)
1	11		30. Name and address of person who chauncey T. Jones,	completed cause of dea		ype. Print) Street, Balti	mare han	21287 -	,	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Locales	more, pro	0.100/	1100	
	negisii									

		-	Please 1 - State Registrar		aryland / Dep <i>Ce</i>		lealth and I	Mental Hy	aiene	.egible. 2005	29079
	ysicia		1. Decedent's Name (First, Middle, Las Frank Albert Hym					2. Date of De Month Sept.	3	Year 2005	3. Time of Death 6:56 P M
1	ledic amin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. C	county of Death	
Fun Dire			5. Social Security Number 6. Sec. 11 6. Sec. 11		e (In yrs. last birthday, 72 ^{Yrs.}		If Under 24 Hrs.	8. Date of Bil (Month, Da Jan. 2	th ay, Year)	9. Birth	place (State or Foreign intry) yland
Maryland	fledat	tor	Usual Residence of Decedent 10a. State 10b. County MD Carroll		10c. City, Town or L						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
h with the	albenot	al Director	10e. Street and Number 5505 Jim Pickett	Road		10f. Zip Code 21784			-	en of What Cou	
C Z1Z1S-5-UU35 filed within 72 hours after death with the Maryland Hygiene. uther then "netural", or Items 23a or 28a-f show	Saminerma	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 K Yes 2 N If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No	Hispanic Origin? (S lan, Mexican, Puert Specify:		p- 14	A. Race - Amer Black, White	ican Indian,
1215-0036 within 72 hours af sne. then "netural", or	Tro Medical	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	i+)	DO NOT use retire	durina most of wor	king		d of Business/l	ndustry
E g g g	event.	To Be Co	17. Father's Name (First, Middle, Last) Jeremiah N. Hymi	ller	Mecha	anic	18. Mother's Nam			Repain	
	ther treumatic		19a. Informant's Name/Relationship (7 Genevieve Hymill 20a. Method of Disposition		e 5505	Jim Pic	kett Road		ville		21784
Baltimore, permit. Pages 1 ar Department of Hea	injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen)		matory or other pla w Mem. Ps 2. Name and Addre	ark Sept	8, 5		sville	
Physic /Med	ian ical		23a. art1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a AS	the death. Do not en		ueen Fune 1d Libert ng, such as cardiac				Approximate Interval Between Onset and Death
/60, te be executed with the second s	e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	c	a consequence of): a consequence of):						
. BOX 6 death certifii e attending p	ched for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23	d. Date of deliv	very Day Year
- E D	peq	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the t	underlying cause gr	ven in Part I.		obacco use		the cause of death?
	page 2	Completed						24a. Was auto perfo 1 🗆 Yes			opsy findings available ompletion of cause of
Phys of	funeral di	ation: To Be	25. Was case referred to medical examiner? 12 yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatie 28a. Date of Injui (Month, Day	ry 28b. Time o	of 28c. Inju	TO SHARE WITH THE PARTY OF THE	th (Check only one 5 ☐ Resi 28d. Describe	dence 6		fy)
_ 0 = =	ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubul	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rui	al Route Number,
To the Hospitel of within 24 hours at the Funerel D		Medical	(Check only one) Medical Exam		of my knowledge, dea examination and/or in ated.	nvestigation, in my	opinion, death occu		date and p	lace, and due	to the cause(s)
230	X)		29b. Signature and title of certifier	Low	~ Ami		1924		Septe	signed (Month) where G	
Th	10		30. Name and address of person who devotes the Hewlerson and 1. Date filed (Month, Day, Year)	S-WN 34	eath (Item 23a) (Type 73 Manches	te RU W	lancheste	mo	,21	102	
Re	Sta gistra	e ar	SEP 0	7 2005	Sissi As	Sparke					

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	1- For State of Maryland / Department of Health and Mental Hygiene 2005 29080 Certificate of Death Reg. No.
Physician /Medical	VIVIAN BITZABECII GACKSOII SANIONADO 3 ZDOS 15. 25 PM
Examiner	Sinai Hospital of Baltimore Baltimore City
Funeral Director	5. Social Security Number 217-24-1861 7. Age (In yrs. last birthday) 73 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. O1 O5 32 9. Birthplace (State or Foreign Country) 01 O5 32 MD
death with the Maryland ms 23a or 28s-f show count be notified at neeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
with the sa or 28a Lbs nutili	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4008 Carlisle Ave 21216 U•S•A•
5 2 E 5	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 No Divorced 1 Yes, Give Year or Dates: 1 Yes 2 No Specify: 1 Never Married 2 Married 1 Yes 3 No Specify: 1 Never Married 2 Married 1 Yes 3 No Specify: 1 Never Married 2 Married 1 Yes 3 No Specify: 1 Never Married 2 Married 1 Nev
Maryland 21215-0036 at 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "natural", or treumatic event, the Medical Exercation or To Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
ind 21 be filed w tal Hygier d other th	18. Morner's Name (First, Middle, Last)
Aaryland 2 should be and Mental is marked or reumatic eve	George Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, Miponerii. Pages 1 and 2 Department of Health a Important: If I tem 27 Is eny injury or other tre once.	Marguerite Johnson-Friend 4008 Carlisle Ave, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore, sernil. Pages 1 a. Department of Hear mportant: If Item ny injury or othe once.	1 \overline{\text{Burial 2 \subseteq} Cremation 3 \subseteq Removal from State 4 \subseteq Donation 5 \subseteq Other (Specify) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Dermi Department of the position of the positi	March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Physician /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myolandial Infanction Due to (or as a consequence of): J
ox 68760, certificate be executed ding physicien and use as the burial-transit	
II Records, P.O. Box 6876. The law requires that the death certificate be cate has been signed by the attending physicic page 2 should be detached for use as the bu Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
cords, P w requires that been signed b should be deta	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records, P.O. Bosicien: The law requires that the death certificate has been signed by the atterfrector, page 2 should be detached for up Be. Completed by Physician	Hypertension 24a. Was an autopsy performed? Stage IV Lung Concer 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
r Vita	25. Was case referred to medical examiner? 26. Place of Death (Check only one)
ng ng line line	
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the t. Medical Certificati	3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hospi in 24 hou the Funer pletely fill edical	29a. Certifier (Check only one) 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the company of the	A1/
10	Hymonism MD. RES-000 September 5 2005 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Dr. Morrison MD Sinai Huspital of Baltimore.
State Registrar	
DHMH 17 Rev 1/2001	ORIGINAL

			State of Maryland / Department State of Maryland / Department	artment of Health and Mer r tificate of Death	ntal Hygier Reg. I	7 0 0 3 7 9 0 0 1
ı	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Magdalene Mary 4a. Facility Name (If not institution, give street and number)	Kenney Se 4b. City, Town, or Location of Death	eptembe	er 4,2005 7:30 A ^M 4c. County of Death
	Examin	er	225 Detriot Avenue	Dundalk		Baltimore
	Funeral Director		5237 38 div 38	If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Yea venber 14	ar) 9. Birthplace (State or Foreign Country) NC.
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	ocation		10d. Inside City Limits
	a-f sh	ctor	MD Baltimore Dund	alk		1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	death with the Maryland ma 23a or 28a-f show r must be rediffed at	Funerai	225 Detriot Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specific	v Vae or No-	USA 14. Race - American Indian,
0000	be filed within 72 hours after death with the Marylan at Hygiene. Identifysiene. In the Hedical Examinar must be notified at event, the Medical Examinar must be notified at	þ	Armed Forces? 1 □ Never Married 2 🖾 Married 1 □ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici	an, etc.)	Specify: White
5	72 ho natur	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b.	. Kind of Business/Industry
7	within ane. then "	mp	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)		Own Home
<u> </u>	e filed withln al Hygiene. I other then ' vent, ine Me	a)	10 Years HO 17. Father's Name (First, Middle, Last)	usewife 18. Mother's Name (Fi		
/Ian	2 should be and Mental is marked o aumatic eve	To B	Thomas Scott	Nannie B	rendle	
, Mar,	5 # Z # G			ng Address (Street and Number or Rural Re Cleveland Avenue		
шоге	Pages 1 ar		IX Boursi 2 Cremation 3 Hemoval from State	sition (Name of natory or other place) 11 Cemetery 7, 200	ær	. Location - City or Town, State
Daltimol	permit. Pages Deportment of Important: if i any injury or o		21. Signature of Funeral Service Licensee	Connelly Funeral Hor 7110 Sollers Point	me Of Du	ındalk,P.A.
	E1311		23a. Part 1. Enter the disease, or or implications that caused the death. To not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or re	espiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ncer		Onset and Death Class
	/Medical Examiner		Due to (or as consequence of):			1 Oum
		Jer	Sequentially list conditions, if any, leading to immediate guesc. Enter Underlying Cause (Disease or injury	MIL		10 100
	ecuted and transii	Examiner	that initiated events c.	Mellitas		2 years
8/00,	ificate be executed g physician and as the burial-transit	ai E	Due td (or as a consequence of):			U
000	tificate ig phys as the	ledicai	d			
O. DOX	w requires that the death certif been signed by the attending should be detached for use a	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
, S.	The law requires that the tte has been signed by th page 2 should be detache	þ	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		2 No 3 Probably 4 Unknown
spiosa	w requ	ompieted			24a. Was an	24b. Were autopsy findings available
		e Comp			autopsy performed 1 ☐ Yes 2 ☑ 1	prior to completion of cause of death?
VII	ysician; is certific director,	0 8	25. Was case referred to medical examiner: 1 □ Yes 2 □ No	26. Place of Death (C		6 ☐Other (Specify)
5	ing Phys	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at 28d. Work?	. Describe how in	
UNISION	Attend death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined	M 1 ☐ Yes 2 ☐ No	Location (Street	and Number or Rural Route Number,
2	tai or A s efter ai Dire ed in b	Certification;	4 Homicide determined building, etc. (Specify)	55, 145(5), 01165	City or Town, Sta	ate)
	To the Hospital or Attending Physicien: within 24 hours stells deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and vestigation, in my opinion, death occurred a	due to the cause at the time, date a	o(s) and manner as stated. and place, and due to the cause(s)
	To t withi To tl	Σ	29b Signature and title of Certifier	29c. License number	29d. [Date signed (Month, Day, Year)
_	102		· year 111	1144793		7/+/0)
U			30. Name and address of person who completed cause of death (Item 23a) (Type, 13b) and 13b. Date filed (Month, Day, Year) 32. Megistrar's Signature	labud hen	ne	Balt 4021222
	Sta Registr		SEP 0 7 2005	palis		

Gerald King 05-5757 AKG

757			rieasi	State of M	nt in Di	/ Dans	delible ink.	. Ensul	re All	copies A	re Leg	ible.	
		•	1 - For State Registrar	State of M	arylano	Cei	artment of F rtificate of	ieaith a Death	na me	ntai Hygi Re	ene20	105	29082
			1. Decedent's Name (First, Middle, L	ast)					2	Date of Death			3. Time of Death
	iysicia Medic		Gerald King							Month August	26, 20	_{Уваг} 005	3:03 A M
	camin		4a. Facility Name (If not institution, g)		4b. City, Town, o	r Location of	Death		4c. Count	y of Death	
			Johns Hopkins H				Baltimon						
	neral ector		217-38-5188	Sex 7. Ag 1 M 2 □ F	ge (In yrs. lasi 64	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, ct 28,	Year) 1940	9. Birthp Cour	place (State or Foreign ortry) unk
and *		-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation					1	0d. Inside City Limits
deeth with the Maryland me 23s or 28s-f show	56	ō	MD				Ltimore						117 Yes 2 □ No
the the 28s-	notifi	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	
with 3s or	5		2325 Eastern Ave	27110				100/			g. C		,.
deeth	1	Funeral	11. Marital Status unl	12. Was Decedent	Ever in U.S.	13.1	Was Decedent of Hi If Yes, specify Cubi	1224 Iispanic Orig	in? (Speci	y Yes or No-	14. Ra	USA ce - Americ	an Indian,
after o	름		1 Never Married 2 Married	Allied Forces					Puerto Rio	can, etc.)		ck, White,	etc.
ours o	Exa	l by	3 Widowed 4 Divorced	Year or Dates:			1 □ Yes 21X No	Specify:			Specia	⁵∵ wh	ite
G Z I Z I 3-0030 filed within 72 hours after Hygiene.	event, the Madical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education trade completed)	1	(Give	dent's Usual Occup kind of work done	during most	of working	unk 1	6b. Kind of E	Business/Inc	dustry unl
Z I Z I D-UUSO d within 72 hours afi giene. er then "naturei", or	e Me	d d	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retire	d)					
Hygie	를	ပ္ပ	unk 17. Father's Name (First, Middle, La.	unk			unk	18 Mother	e Name (First, Middle, M	aiden Suma	mal	
and the mital in	•	Be	Tr. Famor S Name (r mai, minare, ca							da Winw		110)	
Maryland d 2 should be file th and Mental Hy 7 is marked oth	meti	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street					State Zin	Code
Mar 27 is	other treumatic		O.C.M.E.	(1)	1		Penn Str					_	(0000)
	othe		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place	eer ba	Dat		Oc. Location		own, State
Pages ment of la	ury or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☑ Other (Spec	Removal from State		өнөгу, стөг	natory or other plac	(Ce)					
DAILIMORE, permit. Pages 1 a Department of Hec Important: if item	any inju		21. Si nature di runeral Servic Lio Ron al d. S.	ensee //	ector		Name and Addre			655 W.	Raltim	ore S	treet
			Z3a. Part1. Enter the disease, or co	mnlications that cause	d the death	Ва	utimore.	MD = 2	1201			ore b	Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each I	line.						st,		Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)	a Arterio	osclero	tic (Cardiovas	cular	Dise	ase			
Exam				Due to (or as	s a consequer	nce of):							
	ă.	9	Sequentially list conditions, if any, reaumy to immediate cause. Enter Underlying Cause (Disease or injury that include specials)	b. Due to (or as	s a Conseque?	ice of).							
uted d	ansit	Examiner	Cause (Disease or injury that initiated events										
/oU, le be executed ysicien end	rial-tı		resulting in death) Last										
ate be ex	he bu	cai		d.									
artifica ing ph	a as	Med	IF FEMALE:									- 1	
he death certifical	led for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 ☐ Fetal de	eath 3	Ectopic pregnancy Other (specify)	/				ate of delive onth	ery Day Year
hat the d by th	letach	된	Part II. Other significant conditions	t contributing to dooth i	but not socialis	ea ie the u	- dagbina	i- D-41	· · · · · · · · · · · · · · · · · · ·	22a Didash		4-2h	ne cause of death?
wrequires that been signed b	should be detached	ed by	Partin Other significant conducting	contributing to death t	Dut not respitir	ng in the u	nderlying cause giv	en in Part I.					ne cause or death? pably 4 ∐Unknown
has bas	96	Completed							_	24a. Was an autopsy perform		Were auto prior to cor death?	psy findings available impletion of cause of
	or, pa	Ö	25. Was case referred to medical	1				OO Diana	-101-1	1 Yes 2		1 🗌 Yes	2 🕱 No
Of VICE Physicien:	director,	O B	examiner? XXYes 2 □ No	Hospital: 1 ☐ Inpati	ient 2X FB	l/Outnatier	it 3 DOA Oth	oc		Check on one 5 ☐ Resider		ner (Specif	i.i
	funeral dir	Ë	27. Manner of Death	28a. Date of Inju	ury 28	Bb. Time of				d. Describe how			77
VISION Attending r death.	e fur	ate	1 Accident 5 Pending investigat		ay 16ai)	Injury		Yes 2 □ N	lo				
DIVISION i or Attending efter death. Director: Afte	in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of in	njury - At home tc. (Specify)	e, farm, str	eet, factory, office		281	Location (Stre City or Town,	et and Num. State)	ber or Rura	il Route Number,
UIVISIO To the Hospitei or Attendi within 24 hours efter death. To the Funarei Director: A	etely filled in by the	Medical C	29a Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the basis aminer: On the basis of and manner si	of examination	idge, death n and/or in	occurred at the two	na, date and pinion, death	l place, and h occurred	dua to the cau at the time, da	ma(t) and m e and place,	and due to	lated. the cause(s)
o Mithin	сошр	Me	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signe	ed (Month,	Day, Year)
			> Chies	٢			0.	C.M.E.			August	26,	2005
			30. Name and address of person what Ana Rubio, MI				Print) 1 Street,	Ralti	imore			1201	
	Sta	te	31 Date filed (Month Day Year)	39 Regist	rar's Signatur	0				, -aar y 10		OT	
Re	egistr		SEP 0 7 20	05	J. D.	623	المناك						
DHMH 17 F	Rev 1/21	001		A colonial and	A Street of	-				57.0175			

DHMH 17 Rev 1/2001

			1 - State of Registrar	Maryland		rtment of H <i>rificate of L</i>	ealth and Me Death	ntal Hygie Reg.	2003	29083
			Decedent's Name (First, Middle, Last)				2.	Date of Death	Day Your	3. Time of Death
	Physici /Medio	al	Michael Joseph Krystofia			th Ch. Town	Laurian of Dooth	Month 4	Day 2065	17.101TM
	Examir	er	4a. Facility Name (If not institution, give street and num Franklin Square H65P	1	enter	R 55	Location of Death	Anny just 10 years again	Rolf	more
	Funeral Director		5. Social Security Number 6. Sex 17−14−0520 1 1 1 M 2 I F	7. Age (In yrs. la 84	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min. 9	Date of Birth (Month, Day, Ye / 25 / 1920		nplace (State or Foreign untry) aryland
	D .		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Marylan -f show fled at	to	MD Baltimore			Quarters				1 ☐ Yes 2 / ⊡/No
	or 28e	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What Co	untry?
	23a	a	3834 Clarkes Point Road			21220			U.S.A.	
36	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or Iteme 23a or 28e-f show event, the Medical Evarifier must be multified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Ves 3 □ Widowed 4 □ Divorced 12. Was Decer Armed For 1 □ Yes If Yes, Give Year or Da	2 🔀 No 9	1	as Decedent of Hi Yes, specify Cuba □ Yes 2⊠ No	spanic Origin? (Specif n, Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Wh	
2-00	72 hou		15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occupa	turing most of working	168	b. Kind of Business/I	ndustry
21215-0036	2 should be filed within and Mental Hygiene. Is marked other than "eumatic event, the Mes	Completed	Elementary/Secondary (0-12) College (1-	4or 5+)	life. De	ONOT use retired, Shop Owne)		Own Busin	ess
	Hygid other ent, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name (F			
'lan	Mental Mental arked o	ToB	Henry Krystofiak				Frances	Spoich		
Maryland	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (Type, Print)				and Number or Rural R		_	
	is 1 and 2 should of Heelth and Mer item 27 Is marke other treumatic		Janet Krystofiak/Wife	20h PI	3834	Clarkes	Point Road		s Quarter	s, MD 21220
Baltimore,	# O		20a. Method of Disposition □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□			ition (Name of atory or other place of Faith	9/8/05		altimore,	
Balti	permit. Page Depertment of Importent: If any injury of QDCs.		21. Signature of Juneral Service Licensee		22. 62	Name and Addres	^{is of Facility} Mille Lr Road Bal	r-Dippe	1 Funeral	Home Inc.
	-		23a. Part . Enter the disease, or complications that ca	used the death						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	BXIO	_					Onset and Death
	/Medical Examiner		resulting in death)	or as a consequ	uence of):					
0	ALEXAN.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	or as a consequ	ience of):	_				
	ecuted and transi	Examin	that initiated events c. 120	or as a consequ	0110	ire				
68760,	ificate be executed g physicien and as the burial-transit		d d	ii as a consequ	ierice or).					
687	± on et	edicai	0.							
O. Box	The law requires that the death certifule has been signed by the attending tage 2 should be detached for use an	Physician/M		nth 2 ☐ Fetal unt at time of de	death 3 E	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of deliv Month	very Day Year
ds, P	signed b	by	Part II. Other significant conditions contributing to de	ath but not resu	ulting in the und	derlying cause give	en in Part I.	23e. Did tobac	co use contribute to	/
COL	w require been signal	iete						24a. Was an	24b. Were aut	topsy findings available
of Vital Records,		Completed						autopsy performed 1 Yes 2	death?	ompletion of cause of 2□ No
/ita	Phyeiclen: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death (C	Check only one)		
of \	shye this al dii	٩			ER/Outpatient	3 DOA Othe	4 Nursing Home	5 Residence	e 6 Other (Spec	ify)
	ding f h. After funer	tion	27. Manner of Death Natural 5 Pending Accident investigation	Day Year)	28b. Time of Injury	28c. Injury Work		. Describe now i	injury occurred	
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At hor g, etc. (Specify,	me, farm, stree	et, factory, office	28f.	Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
_	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the leading the leading physician of t	sis of examinati						
.	To the Within To the	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	, Day, Year)
-	w		30. Name and address of person who completed cause	of death (Item	23a) (Type, P	rint)	• •		1100	
5			Of charisse Davenfort 90	00 Fra	nklin	Square	DriveBo	xItime	(e,M)	21237
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Re SEP 0 7 2005	gistrar's Signati	ture	all of			,	

Krystofiak, Michael

			1 - For State Registrar	State of Maryland / De $_{ m C}$	partment of Health and leartificate of Death	Mental Hygier Reg. ۱		29084
	Physici		1. Decedent's Name (First, Middle, Last)	Lolonski		2. Date of Death Month	Day Year	3. Time of Death 9400 M
	/Medio Examin		4a. Facility Name (If not institution, give stre	eet and number)	4b. City, Town, or Location of Deat	September	4c. County of Death	
			Genesis Perrine Parkw 5. Social Security Number) 6. Sex	7. Age in yrs. last birthda	Park Ville If Under 1 Year If Under 24 Hrs	O Date of Birth	Balymore	و
	Funeral Director		201-24-6257 101	41	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	i. Penns	ace (State or Foreign
	yland Now		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10	d. Inside City Limits
	8e-f st	Director	MD Hartor	d Jo	TI TI			1 ☐ Yes 2 XNo
	with th	Dire	10e. Street and Number 412 FOSter Kno	UNR	101. Zip Code	10g. (Citizen of What Country	ry?
	r death	Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. 1: Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yos or No- o Rican, etc.)	14. Race - America Black, White, e	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-1 show eny injury or other treumetic event, Ite Mancal Examiner and be mailfied at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	,	Specify: 12) hr	10
21215-0036	72 ho "natur	To Be Completed	15. Decedent's Educat (Specify only highest grade c	ompleted) (Gi	cedent's Usual Occupation ve kind of work done during most of wo	nking 16b.	Kind of Business/Indu	ustry
2121	filed within Hygiene. Ither then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		+ home a	
	be filed stal Hyg ed other event,	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	en Sumame)	1
Maryland	should be ind Mental imarked c	은	19a. Informant's Name/Relationship (Type,	Print) 19h Ma	illing Address (Street and Number or Ru	lanie Lu	Kastesk	Code
	and 2 sho lealth and m 27 is m		Stanley B. Loha	Ski 412	Foster Knoll Di	Troop	mD 210	35
ore	Pages 1 and of He out: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	cometery, c	position (Name of rematory or other place)		Location - City or Tow	
Baltimore,	permit. Page Department of Importent: If eny injury of		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee	Dubuy	alloy Men Cardens 9- 22. Nat e and Address of Facility A	4.05 Ii	monium	MD
Ba	permi Depa Impo eny ir		Kimberly G.	Sauratry 1	EVANS FUNERALCHA	EL 8800 HA	REPORDER	5
			23a. Part 1. Enter the disease, dr complications shock, or heart failure. List only one	ions that caused the death. Do not ecuse on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	where Performany	Dassas		51,001 4118 50411
i	Examiner		Sequentially list conditions b.	Due to (or as a consequence of).				
	ted nsit	Examiner	Sequentially list conditions, it my landing to imm solutions cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons ∗uence of):			1.1	
oʻ	execu an and rial-tra	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
68760,	ificate be executed g physician and as the burial-transit	edicai	d.					
Box 6	death certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy			23d. Date of delivery	y
P.O. B	w requires that the death cer been signed by the attendin should be detached for use	by Physician/M	in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown		B Ectopic pregnancy Discrete Control of the Control		Month E	Day Year
	s that the ned by a detac	y Ph	Part II. Other significant conditions contril		underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
ords	equires		Sich Sinus Si	judrome		1 🗆 Yes	2 No 3 Probal	bly 4 Unknown
Division of Vital Records,	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Completed				24a. Was an autopsy performed?	prior to complete death?	sy findings available pletion of cause of
ita	Physicien: The lav this certificate has al director, page 2	BeC	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	No 1 ☐ Yes 3	No No
of <	Physic this ceral dire	ို	1 ☐ Yes 2 🗖 Ño	pital: 1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury 28b. Time		ome 5 Residence		
ion	nding ath. r: After e fune	ation	1 Netural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		Zod. Describe flow in	ary occurred	
) jvis	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural i	Route Number,
_	ospital hours a uneral y filled	alCe	29a. Certifier Certifying Physici	ian: To the best of my knowledge, de	ath occurred at the time, date and place	, and due to the cause	(s) and manner as sta	ted.
	the Hohin 24 the Fu	Medical	one)	and manner stated.	investigation, in my opinion, death occu			
	Will To		29b. Signature and title of certifier	· · ·	D 200 200 110111001		Date signed (Month, Di	
	i		30 Name and address of person who comp	oleted cause of death (Item 23a) (Typ	e, Print)	x f	Hember 6	2,00
	Sta	te.	March Teinberg Gold	32 Registrar's Signature	tal Prof Building #	303 Balton	note MD 2	1239
	Registr		SEP 0 7 2005	Alexand St Ap	sell)			

			1 - For State Registrar	State of Maryland / [Department of Health and Certificate of Death	d Mental Hygi	ene 200	
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last, Littleton Aa. Facility Name (If not institution, give Union Memorial	St.Paul	Langley 4b. City, Town, or Location of Di Baltimore	2. Date of Death August	Day Year 25, 200 4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sec	7. Age (In yrs. last bin	thday) If Under 1 Year If Under 24 H	8. Date of Birth (Month, Day, 06 16	Year) 9. Birt Co	nplace (State or Foreign untry) VA
	Maryland e-f show	ctor	10a. State 10b. County MD NA	10c. City, Town Balti				10d. Inside City Limits 1 Yes 2 □ No
0	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "neturel", or terms 23e or 28e-f show event, the Medical Enginer institut to notified at	Funeral Director	10e. Street and Number 2 North Smallwo 11. Marital Status 1 □ Never Married 2 □ Married	od Street Apt 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 20 No If Yes, Give	10f. Zip Code 206 21223 13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Po		U S A 14. Race - Ame Black, Whit	rican Indian, a, etc.
2 1 3-000 C	vithin 72 hours a ne. hen "neturel", o ne dical Eral.	Completed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Ed. (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates:	1 ☐ Yes 2 No Specify: Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)		Specify:	
ylain 6.	should be filed within and Mental Hygiene. marked other then umatic event, the Mental Color.	To Be Cor	12th grade 17. Father's Name (First, Middle, Last) Cornelius Lang	na ley	Rebec	Name (First, Middle, M ca Smith	daiden Sumame) Langley	Hospital
ore, mar	perriit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 le marked any injury or other treumatic e <u>once</u>		19a. Informant's Name/Relationship (T) Mildred Frankli 20a. Method of Disposition 1★ Burial 2 □ Cremation 3 □ F	God n-Daughter 96 Removal from State	Mailing Address (Street and Number of 518 Axehead Cour Disposition (Name of y, crematory or other place)	ct, Randa Date	11stown,	Md 21133 Town, State
Dalillio	pernit. Pa Departmen Importent any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	* Dunt	land National 9, 22. Name and Address of Facility March F/H West 4300 Wabash Ave	e, Baltim	ore, Ma	21215 Approximate
	Physician /Medical		2 a. Par 1. Enter the disease, or comp styck, or heart failure. List only o Immeriate Cause (Final disease or condition restiting in death)	a Septimized Septimized Laborated		diac or respiratory arre	ist,	Interval Batween Onset and Death 5 days
,007	te be executed ysician and purial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence Due to (or as a consequence	of):			Sdays
O. Box og	The law requires that the death certificate be executed tite has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ras, r.	quires that t in signed by uld be deta	by	Part II. Other significant conditions co	intributing to death but not resulting i	n the underlying cause given in Part I.		acco use contribute to	the cause of death?
al Records,	The lar ate has page 2	Completed					y prior to death? ■No 1 □ Yes	utopsy findings available completion of cause of
on or vital	ding Physicien: h. After this certific funeral director,	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury 28b.	Other	Death (Check only only only only Home 5 Reside 28d. Describe home		cify)
DIVISION	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (St. City or Town	reet and Number or Ri , State)	ural Route Number,
	the Hospit in 24 hours the Funere	edicai	(Check only 2 Madical Exam	iner: On the basis of examination ar	e, death occurred at the time, date and p nd/or investigation, in my opinion, death	occurred at the time, da	ate and place, and due	to the cause(s)
1	with To I	Σ	29b. Signature and title of certifier	. Leway M.D.	AT24389	46 /	HUPUST 2	5,2005
J.		nto.	30. Name and address of person who of Latring C. L.	empleted cause of death (Item 23a)	29c. License number AT243894 (Type, Print) Union Memorica	4 Hospita	1 Balt	mere MD
	Regist	ate rar	31. Date filed (Month, Day, Year)	ZERLES A	100			

		·	1 - For State Registrar	State of Maryl		artment of H tificate of L			iene 0 C _{eg. No.})5	29086
П	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month		Year	3. Time of Death
	/Medic	al.	Lola E. Luers 4a. Fecility Name (If not institution, give	stroat and aumbor)		4b. City, Town, or	Location of Doo	Sept	1 2005		11:38 PM
	Examin	ier	Northwest Hospital			Randalls		ın	4c. County o		
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Baltim	9. Birthpla	ace (State or Foreign
L	Director		217-12-0403	☐M 2[XF	81. Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Day Sept. 23	, 1923	Mai	yland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10	d. Inside City Limits
	Maryl -1 sho lied a	ō	Maryland Baltime	ore	Randa	11stown				1	1 ☐ Yes 2 ☑ No
	r 28e	Director	10e. Street and Number	11		10f. Zip Code		1	0g. Citizen of Wh	nat Counti	ry?
	23a c		3807 Brownhill	Road			21133		United :	State	28
36	d within 72 hours after death with the Maryland gene. Ir then "naturel", or Items 23a or 28e-1 show Itte Macileal Examinet rrust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☼ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	l l	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (5 n, Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Race Bfack, Specify:	White, e	tc.
9	2 hour	ted t	15. Decedent's Edu	cation	16a. Deced	ent's Usual Occupa	tion		16b. Kind of Bus		
21215	within iene.	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12th	College (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired) Homema		orking		home	•
Maryland 21215-0036	2 should be filed and and Mental Hygier Is marked other raumatic event, It	To Be C	17. Father's Name (First, Middle, Last) James P. Monaha	n				me (First, Middle, Miller	Maiden Sumame)	
lary	2 sho and h Is ma auma		19a. Informant's Name/Relationship (7)					ural Route Number			
	l and lealth im 27 her tr		Clinton Lawrence			Brownhill	L Road	Randallst			133
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic evone.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	Community on Change	ake View	natory or other place Mem. Pai	ck Sept	. 6, 2005		ville	e, MD
Bal	permit Depar Impor eny in	. 10	21. Signature of Funeral Service Licens	au				eral Home ty Road		tory d, Mi	pA 21784
	Pnysician /Medical	١	36a. Paht1. Enter the disease, or compi spock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that called the dine cause on fact line. a	eath. Do not ente	1 1	such as cardia r Hov	-	est,		Approximate Interval Between Onset and Death
	Examiner und und und und und und und und und und	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Casas of Injury that initiated events	Due to (or as a cons	sequence of):	-					
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a cons	sequence of):						
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O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of Month		∕ Day Year
Records, P.	uires that the signed by a signed by a detact	ρλ	Part II. Other significant conditions co	ntributing to death but not	resulting in the un	derlying cause giver	n in Part I.	23e. Did tob	acco use contrib	ute to the	
000	s been s should	ompleted						24a. Was ar	24b. We	re autops	sy findings available
	The law requires ate has been sign page 2 should be	omi						autops perform 1 Yes 2	ned? pric	or to comp ath? Yes 2	pletion of cause of
Vital	ysicien; Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one	-	3.00 2	
of <	Physicien; this certific ral director,	2	1 □ Yes 2 No		☐ ER/Outpatient		4 Nursing F	lome 5 Reside	nce 6 Other	(Specify)	
		ion	27. Manne of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injury	?	28d. Describe ho	w injury occurred		
Division		flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	t home, farm, stre		es 2□No	28f. Location (Str	eet and Number	or Rural F	Route Number
2	in Line	Certification;	4 Homicide determined	building, etc. (Spe	ecify)	on racioty, office		City or Town	State)	071101011	iodio ivambol,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physical Exemi	sicien: To the best of my kner: On the basis of exam and manner stated.	rnowledge, death ination and/or inv	occurred at the time estigation, in my opi	e, date and place nion, death occu	a, and due to the ca arred at the time, da	use(s) and mann te and place, and	er as stated	ed. ne cause(s)
ì	To the within To the comp	Me	29b. Signature and title of certifier	1	26	29c. License			d. Date signed (/	Month, Da	ay, Year)
	_		30. Name and address of person who co	impleted cause of death (I	tem 23a) (Type. F	Print)	- (/	8	11 1	10	7/220
_	8		ar arelius 1). Albuer	rong a	v 5/1	6N. B	Mi kd	Bul	60	5 2/228
:	Sta Registr		31. Date filed (Month, Day, Sear)	32. Registro s Sig	gnature H.	Sperte		1, 2,			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item #9 per ana bd g847 9/07 Gestificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year VARGARET 08 24 2005 1:00 HK 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth ursiNG Center MHIMORE 1046 Old North If Under If Under 24 Hrs. 6. Sex / 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1□M 2X F 476-10-048 Minn. Usual Residence of Deceder 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1046 Old Northpoint Road 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Thiel Lorraine Stemper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1046 Old Northpoint Road Baltimore, MD 21224 of Disposition (Name of Date 20c. Location - City or Town, State Eastpoint Nursing & Rehab Ctr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Si natur of Funeral S rvice Licensee Rona d S . Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street nin Baltimore, MD 21201 23a. Party. Enter the disease or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in death) . CHRONIC OBSTRUCTIVE YULMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last BETES ME LLIT (as Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown EMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ♠ No † □ Yes 2010 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 DNatural 2 ☐ Accident 5 Pending 1 Tes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

ettending physicien end for use es the buriel-trensit The law requires that the death certificate be executed signed by the et d be deteched for or Attending Physician:

Division of Vital Records, P.O. Box 68760.

certificate hes been signe lirector, page 2 should be the funerel director, After this efter death. filled in by

Physician/Medical Examine

Completed by

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Certification: To

edical

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/Medical

Examiner

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Peges 1 end 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mentel Hygiene.

ant: if Itam 27 is marked other than "natural", or itams 23s or 28s-f show ury or other traumetic event, the Medical Examinar must be notified at

ortant: if h

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

25. Was case referred to medical		26. Place	Death (Check only
examiner?	Hospital:	 Other:	

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

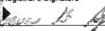
29a. Certifier (Check only one) The critifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mainer as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar



24 hours

To the P within 2 To the P

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			1 - For State Registrar	State of M	Marylar		artment rtificate			ind M		giene 10g. No.	200	5	29088
	Physic		Decedent's Name (First, Middle Marjorie Rose	, ===,							2. Date of Dea Month 09		Year 2005		3. Time of Death 9:10 PM
	/Medi Examir		4a. Facility Name (If not institution	, give street and numbe	or)				ocation of	f Death	09	4c.	County of Dea	ath	9.10 FM
	Funeral		Stella Maris F 5. Social Security Number		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	Baltime 9. Bi		e (State or Foreign
	Director		214-20-3054 Usual Residence of Decedent 10a, State 10b, County		80						06/16/1	925		nns	ylvania
	death with the Maryland ms 23a or 28a-f show	ctor	,	cimore		ty, Town or Lo									Inside City Limits 1 Yes 2 No
	with the	Director	10e. Street and Number				10f. Zip					_	ten of What C	ountry?	?
	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other then "natural", or Items 23e or 28e-1 show marked other then "natural", or Items 23e or 28e-1 show marked other the Madical Examiner must be mailfied at	Funeral	3335 Garnet Ro 11. Marital Status 1 □ Never Married 2 Marr	12. Was Deceder Armed Force	s?			234 ent of His rfy Cuban	panic Orig , Mexican,	in? (Spec Puerto F	cify Yes or No- lican, etc.)		.S.A. 4. Race - Am Black, Wh		
-003	2 hours after atural', or ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates	_	16a. Deced	1 ☐ Yes 2		Specify:				Specify: WI	hite	
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lary	2 should and Men is marks	-	19a. Informant's Name/Relations	nip (Type, Print)					d Number	or Rural	Route Number			Zip Cod	de)
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altimore,	permit. Pages Di pertment of in portant: if it any injury or o		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S _i) 21. Signature of Funeral Service I	pecify)	0	aid Ric	lge Ce	mete	ry 0		/2005				
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18	/Medical Examiner		resulting in death)	aCHRONI Due to (or a) PUL	TUNAN	OT DIS	SEASI	<u>. </u>				
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VIII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:		55.0		Other			Check only on	θ)			
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	To the Hospital or Attending Physician: within 24 hours after dealt. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical 8	Physician: To the best examiner: On the basis and manners	of examinat	wledge, death tion and/or inv	occurred a estigation, i	t the time, in my opin	date and lion, death	place, an	d due to the call at the time, da	iuse(s) a ate and p	nd manner as place, and due	stated to the	cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier				29c.	License r	iumber		25	9d. Date	signed (Mont	h, Day,	Year)
	1		30. Name and address of person v	who completed cause of	death (Item	1 23a) (Type, F	Print)	243	72				1/6/0	25	
786	\J Sta	10	DR. TARIQ MAHN 31. Date filed (Month, Day, Year)		DULANI tær's Signa	Y VALI	EY RD). T	IMONI	UM,	MD 2109	93			
	Registr	-19	SEP	0 7 2005		. Je	Acord	6. 2							

			For	State of Marylan				Mental Hyg	jiene	•
			Stata Ragistrar Decedent's Name (First, Middle, Last)		Cei	rtificate of l	Death	2. Date of Dea	leg. N2 0 0 5	
П	Physici		John Hines Moore					Month Septeml	Day Yea	3. Time of Death 1:00P M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dea		4c. County of De	
			Holy Cross Hospita			Silver S			Montgon	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. i	Vre	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day	9. E	Birthplace (State or Foreign Country)
	ס		214-30-0684 Usual Residence of Decedent		72 '''			June 1	6, 1933 Ma	ryland
	arylar show	7	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits 1X\(\text{Yes} 2 \subseteq \text{No} \)
	the M	Director	Maryland Montgomer	y Rock	ville	10f. Zip Code			10g. Citizen of What	
	3a or		4 Monroe Street #2	04		20850			JSA	Country
	ams 2	Funeral		12. Was Decedent Ever in U. Armed Forces?		Was Decedent of H	ispanic Origin? (S	Specify Yes or No-		merican Indian,
36	s atter	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 □ No		1 ☐ Yes 2🌠 No	Specify:	10 1 110411, 0101,	Specify:	
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Exeminer mast be notified at	ed b	15. Decedent's Educ	Year or Dates: 1955— cation		dent's Usual Occup	ation		16b. Kind of Busine	iite ss/Industry
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2	led wi lygien har th	Cou	17. Father's Name (First, Middle, Last)	5+	Attor	ney	40.44-4-4-1-1-	me (First, Middle,	Private Pr	actice
and	d be f ental h ced of c avai	To Be	Roy Penrod Moore					ne Hines	Maiden Surname)	
Maryland	shoul and Ma s marl	ř	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailir	ng Address (Street			r, City or Town, State	, Zip Code) 20906
Σ,	and 2 ealth a n 27 ls		Mary L. Furgurson/						2A Silver	Spring, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R		lace of Dispo emetery, crer	sition (Name of natory or other plac	, –	tember	20c. Location - City	or Town, State
ij	artmer artmer ortant: injury		* 4 □ Donation * 5 □ Other (Specify) 21. Signature of Funeral Service License			1 Cremato			Odenton, M	
Ba	Depa Impo any ii		Bevel & H	1-1+11					ce P.O. E	lox 784 le, MD 21029
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	n. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
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	e deat he atte	Physician/M	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
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110	17/		30. Name and address of person who co				2			-
10	Sta	te	11125 Rockville, P 31. Date filed (Month, Day, Year)				۷			
	Registr		SEP 0 72	32. Redistrar's Signal	At A	carles				

McCarthy, Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes 29090 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20:48 M 4 Charles McCarthy Russell September 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Baltimore Baltimore Hospital 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 ★M 2 F 69 213-34-2673 Maryland Director Feb 4, 1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite M. dical Exacuter must be redifficed at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Director Baltimore Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21215 U.S.A. 6508 Fairmount Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Completed by 3 ☐ Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Disney McCarthy Marie R. Albert L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian E. Griffin 434 W. Myrtle Street Littlestown, PA Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 9/8/05 Woodlawn , 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, Maryland 21136 time 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Hospital Acquired **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for sels none aquellos offi-Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Shinknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a Wasan 2 No 2 100 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License numbe 29b. Signature and title of certifies September 4,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONE 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 2005 State Registrar

			State of Maryland		artment of H				29091
			Registrar 1. Decedent's Name (First, Middle, Last)		tilicate of L		2. Date of Death	j. No.	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of Death	1
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	Funeral Director		5. Social Security Number 6. Sex 12€ M 2□F 7. Age (In yrs. Iai 12€ M 2□F 56	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Y 11/21/	1948 9. 8. Con	nplace (State or Foreign untry) MD
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	with t	늅	7820 Bodkin View Drive		21122		, , ,	U.S.A.	y.
	death ms 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S	. 13.		spanic Origin? (Spec n, Mexican, Puerto F	ify Yes or No-	14. Race - Amer	
o	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "netural", or Itams 23s or 28s-f show aumatic event, it a Medical Evantizer must be notified.		Armed Forces? 1 □ Never Married 2 Married Armed Forces? 1 May Yes 2 □ No 1 9 6 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3 – 1	ryes, specify Cubai 1 ∐ Yes 2 X No	Specify:	ican, etc.)	Black, White	
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	should brind Ments simarked	2	Allyn Norwood Matthews					eth Myer	
Jar	2 sho		19a. Informant's Name/Relationship (Type, Print) Charlene Matthews / Wife					City or Town, State, Z	ip Code) MD 21122
e Û	s 1 and 2 should of Health and Men itam 27 ts marke other traumatic		20a Method of Disposition 20b. Pla	ce of Dispo	sition (Name of	. Da	_	oc. Location - City or	
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	16/2	1	30. Name and address of person who completed ause of death (Item	23a) (Type,				0	
	18		31. Date filed (Month, Day, Year) 32. Registrar's Signati	D	695	Tmer	ICA	21035	
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State of Maryland / Department of Health and Mental Hygien 2005 29092 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Р. Month Year **Physician** RAYMOND MONTGOMERY eptember of 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HAGERSTOWN WASHINGTON COUNTY HOSPITAL WASHINGTON 7. Age (In yrs. last binthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 ☐ F 8. Date of Birth 0272471939 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 66 215-34-3896 MARYLAND Yrs. **Director** Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD WASHINGTON 1 Yes 2 No HAGERSTOWN Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 837 GEORGIA AV. USA filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Argned Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry HERALD MAIL Elementary/Secondary (0-12) College (1-4or 5+) CONTRACT HAULER 12 .. Pages 1 and 2 should be filed vitment of Health and Mental Hygie tent; If item 27 is marked other filery or other traumatic event, in other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LILLIAN DeFLAGE VIRGIL MONTGOMERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROL JEAN MONTGOMERY/SPOUSE 837 GEORGIA AVE., HAGERSTOWN, MD 21740 20b. Place of Disposition (Name of MARANATHA BARDENS 20a. Method of Disposition 20c. Location - City or Town, State SEPTEMBER 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ENTOYBMENT MARTINSBURG, WV permit. Page Department of Importent: If any injury or once. 3, 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 401-Karles 327 W. KING ST., MARTINSBURG WV 25402 Drawn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician SEISLS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last GASTRO-INTESTINAL HEMDARHARE, SITE UNIFIERMINE Examine to (or as a consequence of): physician and the burial-transit To the Hospitel or Attending Physician; The law requires that the death certificate be executed 7-2526 CUTHNEOU LJMPHOMA Due to (or as a consequence of): Box 68760. Completed by Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 1 Yes 2□ No 2 No Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0001040 09-01-05 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGENSTOWN, MD 21740 BARKY COKEN, 322 E. HATKETIM ST 31. Date filed (Month, Day, Year) 32. Registrar Signature State Alases S. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 05 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** September 1, 8:00 ELSIE LOUISE **McGEE** 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pocomoke City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7752 Pocomoke River Road Somerset 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Yrs. Director 2, 1909 220-12-1407 Maryland October Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f ahow 1 ☐ Yes 2 No Director Maryland Somerset Pocomoke City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Items 23a or? 7752 Pocomoke River Road 21851 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates: traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grower Poultry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward R. McGee ဂ Edith Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 291 - Pocomoke City, MD 21851 Jean T. Taylor (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of hamportant: If its any injury or of once. 1 ∠Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Salem U. M. Church Cemetery 9/3/05 Pocomoke City, Maryland 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw—Pruitt 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ementia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) burial-Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mmths? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? 2 **N**o 1 ☐ Yes Division of Vital Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1. Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 154422 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21851 60 4-Mar ocomok 32. Registrar's Signature State 2005 Registrar KREEFER

			1 - For State Registrar	State of Mary		artment of H tificate of L			ene 2005	29094
	Physicia		1. Decedent's Name (First, Middle, La	Giles	Maur.	ey		2. Date of Death Month September	Day Year	3. Time of Death 5 0700 M
	/Medic Examin		4a. Facility Name (If not institution, gir HOWARD COUNT)	GEN. HOSP,	TAL	COLVI	Location of Death ABIA		4c. County of Death	RD.
	Funeral Director				yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		ryland
	Maryland -f show	tor	10a. State 10b. County MD Howard	l l	c. City, Town or Lo	cation		·		10d. Inside City Limits XXYes 2 □ No
	th the	lirec	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	untry?
	ath wi	raiC	6528 Smokehous			21045			USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Erac, it at must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ◯ ♥ Divorced	12. Was Decedent Ever Armed Forces? 1XXYes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
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212	filed within Hygiene. other than "	Com		5+	High	School			Public	Schools
Maryland	I be file	Be	17. Father's Name (First, Middle, Las Giles Maurey	")				e (First, Middle, Ma Maria B		
يَّ	2 should be and Mental is marked (2	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a			City or Town, State, Z	ip Code)
N N	1 and 2 Health ar Iem 27 is		Theresa Yodzis) 1178	9 Frede	rick Rd	Ellic	cott City	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once.		20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of	_Hemoval nom State		sition (Name of natory or other plac ke Crem	. ا ده	30	oc. Location \cdot City or 1	
Balt	permit. Departr Importa any inji		21. Signature 1 uneral Service Lice	Insee /		Name and Address Name Twin	AA T		neral Ho lumbia,	mes, Inc. MD 21045
8760,	death certificate be executed Agrana and eathending physician and ior use as the burial-transit	dicai Examiner	23a. Part. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sauntially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	MYOCA HYPO	COIM VOLEA Abdom	INFA	CFIDA		Approximate Interval Between Onset and Death
O. Box 6	death certifi e attending p id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli- Month	very Day Year
S, P.	es pe	by	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	on in Part I.		cco use contribute to	
of Vital Record	e law has b	Completed	\\ \(\lambda \cdot \cdo	in ATh	no Sch	crosin	e	24a. Was an autopsy performe	prior to death?	topsy findings available ompletion of cause of
/ita	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?	11in-l				(Check only one)		
of \	Phys this ral di	- T	1 ☐ Yes 2 ☐ No 27. Manner of eath	Hospital: Impatient 28a. Date of Injury	2 ER/Outpatier 28b. Time of		4 14d131119 110	me 5 Residence 28d. Describe how	ce 6 Other (Spec	ify)
ion	Attending If death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Injury	Work	(? Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	i ite	Certification;	3 Suicide 6 Could not 4 Homicide determiner		At home, farm, str pecity)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medical Exe	hysician: To the best of m miner: On the basis of exa and manner stated.		vestigation, in my or	oinion, death occur	ed at the time, date	and place, and due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of pertifier	XW	MI	29c. License	number	29d	Date signed (Month	Day, Year)
1	1-1		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	iss Fer	AN RO	Bn - 111	1 2000
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7	32. Begistrar's		parte	OS (ER)	(/ / / / / / / / / / /	74.70	1-21

State of Maryland / Department of Health and Mental Hygienez 29095 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 1601 oh Meyer 7:30A M Sept 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 Radstock Road Catonsville

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F Yrs Director 214-54-1307 62 August 8, 1943 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ "natural", or Items 23s 312 Radstock Road 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itel any injury or other traumetic event, the Modical Examinations. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No þ Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customs Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William E. Meyer, Sr. Johanna D. Cooney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Radstock Road, Catonsville, MD 21228 William E. Meyer, Jr.-brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 9-6-2005 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP., INC. Jeffer 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Due to (r as a consequence of): LLKL /Medical Examiner ADZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 일 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after deu. 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) scpt 03, 2005 051811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Rulling Nd 1170 Balton 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 29096 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 09-05-05 Catherine E. Miller 2:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice Center Baltimore | Months | Days | Hours | Min. | 8. Date of Birth | Months | Days | Hours | Min. | 08-22-1923 9. Birthplace (State or Foreign Country)
St. Louis, MO 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F 82 577-28-6766 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County worke 10a. State ir then "natural", or Iteme 23a or 28a-f ehov Tre Medical Exercices must be notified at Yes 2 No Elkridge Director MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21075 7012 Lennox Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Treasury Dept. Federal Gov. Department of Health and Mental Hyg Important: If Itam 27 is marked other any Injury or other traumatic exceptions 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Batterton Carl C. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7012 Lennox Ave., Elkridge, MD 21075 Elizabeth McMillen/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09/09/05 Arlington, VA Columbia Gardens 4 ☐ Donation 5 ☐ Other (Specify) Barry of Address finding Funeral Home @ Meadowridge MP e of Funeral Service Licensee M01378 7250 Washington Blvd., Elkridge, MD 21075 23a ant. Enter the isea and conclusions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer wonters olon Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2/2 No certificate 26. Place of Death | Check only one | 25 Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No DSPLU 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After Natural 5 Pending 1 Yes 2 No investigation neral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 - Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 Segtimber 5, 2005 M

State

Registrar

CATHERINI

mo 6601 N- Charles St tonson, no 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 7 2005

32. Rigistrar's Signature

MANON Charles

31. Date filed (Month, Day, Year) SEP 0

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death

2. Date of Death

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-	1	U	1	

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Physician	ŀ
/Medical	ŀ
Examiner	ı

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or Items 23a or 28e-f show importent: if item 27 is marked other than "naturel", or Items 23a or 28e-f show injury or other treumatic event, I'm Medical Exercities Invalide notified at once.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hoepitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

ian	2 2										2. Date of De Sept 2		0 05	Year	3. Time 6	of Death P.M.
ical ner	4		of not institution, given	re street and numbe	ər)	•		Town, or olumb	Location o	of Death			c. County Howa			
		5. Social Security N 149.20.8	149	Sex 1 □ M 2 💢 F	Age (In yrs. I 92	ast birthd Yrs	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April	th <i>y, Year</i> 29 ,	1913	9. Birthp Coun New	J er	or Foreign Sey
tor		Jsual Residence of 10a. State MD	10b. County Howar	đ	10c. City	, Town o	or Location D1a							1	0d. Inside (City Limits
Director	5	10e. Street and Nu	mber tom Court	t			10f. Zip	Code 1044				-	itizen of V USA	hat Coun	try?	
Completed by Funeral		11. Marital Status 1 Never Marr 3 Widowed	ied 2 M arried	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? ∑ No	S.	13. Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		14. Race Blac	- Amenc k, White,		
moleted	-	Elementary/Seco	15. Decedent's E city only highest gr ondary (0-12)	a de completed) College (1-40	or 5+)	(G lit	ecedent's Usua Give kind of wo	rk done d se retired	ation furing mos	t of worki	ing		Kind of Bu			
Ö	-	12	(First, Middle, Las	5			Teacher	2	18 Mothe	ar's Name	e (First, Middle					
Be											Davis	,		-/		
P	-		nsing Sm: ame/Relationship			19b. M	failing Address	(Street a			al Route Numb	er, City	or Town,	State, Zip	Code)	
		Isaiah 1	A. McCoy	Jr.—Husl	oand -	51	69 Phar	ntom	Cour	t. C	olumbia	, M	d 210)44		
				□Removal from Sta	te C	emetery,	isposition (Nar crematory or c eake Cr	other plac			2005		Location - ltsvi	•		
		21. Signature of Fu	uneral Service Lice	uma-		4	22. Name ar 5555 Tw			AAT	tzke Fu . Colum					
		23a. Part1. Enter shock, or hea	the disease, or cor art failure. List only	nplications that cause on each	sed the death	n. Do not	t enter the mod	de of dyin	g, such as	cardiac o	or respiratory a	rrest.			Approximation Interval Be Onset and	etween
		Immediate Cause disease or condition resulting in death)	on	a. LER	EBR	0/0	aseul	ak	140	Cesh	DENT					
Ilcal Examiner		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LEREBRO VOSCULOR ALCIDENT Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): A THEROSCIENOSIS Due to (or as a consequence of): d.														
vslclan/Medical		IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months?		n 2 ∏Fete tat time of d	Fetel death 3 Ectopic pregnancy							23d. Dat Moi	e of delive	nry Day	Year
Completed by Phys			ificant conditions	contributing to deat	h but not res	ulting in th	he underlying o	ause give	en in Part I		23e. Did 1		use conti		ne cause of ably 4 [f death?
Pfo											24a. Was	an	24b. V	Vere auto	osv findina	s available
8											auto perfo	psy ormed?	5	rior to cor leath?	npletion of	cause of
Re C.		25. Was case refe	rred to medical	1					26. Place	e of Deatl	1 ☐ Yes h (Check only o	2001	10	1 105	2 110	
TO B		examiner?	No	Hospital: 1 □ Inp	atient 2	EP/Outp	atient 3 DC	Othi	er: 4 🗆 Nı	ursing Ho	me 5 Tesi	dence	6 □Oth	er (Specif)	1)	
ation.		27. Manner of Dea Natural 2 Accident	th 5 Pending investigate		Injury Day Year)	28b. Tin Inju	ne of a	28c. Injun Worl	yat k? Yes 2□	1	28d. Describe	how inj	ury occurr	ed		
Partific		3 Suicide 4 Homicide	6 ☐ Could not determine	A 286. Place of	Injury - At ho , etc. (Specif	ome, farm	n, street, factor	y, office			28f. Location (City or To			er or Rura	l Route Nu	imber,
Medical Certification.	3000	29a. Certifier (Check only one)	2 Medical Exa	Physician: To the basi aminer: On the basi and manner	e of evamina	tion and/	or investigation	in my or	ninion des	ath occurr	red at the time	date a	nd place :	and due to	the cause	n(s)
2		29b: Signature and	d title of certifier	and manner completed cause CAS M 7 2005	-		29	c. Licenso	onumber 403	59		29d. D	ate signed	(Month,	Day, Year)	
		30. Name and add	fress of person who	ck5 M	of death (Item	23a) (Ty	o Spe	ven	FU	RES	T Rd,	C	lum	67	mo 2	1046
tate trai		31. Date filed (Mon	SEP 0	7 2005 32. Re	istrar's Signa	ature	Frank									

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 2005 6:30P. M Paul Richard Myers September 4 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Mariner Health Care Baltimore 8. Date of Birth (Month, Day, Year)
Jan. 28,1928 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**ĕ**M 2□F Yrs. 216-20-9473 Maryland Director Usual Residence of Decedent 10d. tnside City Limits 10c. City, Town or Location 10b. County ii Hygiene. other then "naturei", or iteme 23e or 28e-f ehow vent, tre Modical Exercitiest invat te rictiffed at 1 ☐ Yes 2 No Maryland Howard Ellicott City Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9605 Ashmede Drive 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Colfege (1-4or 5+) Elementary/Secondary (0-12) Social Security 12 Clerk Peges 1 end 2 should be filed w riment of Heelth and Mental Hygle rtant: if item 27 ie marked other t njury or other traumatic event, ID filed 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Edward Myers Mildred Marie Peters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9605 Ashmede Drive Ellicott City, MD 21042 Charles E. Myers (Brother) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of Important: if any injury or once. 9-8-2005 Woodlawn Cemetery Woodlawn, Maryland 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1630 Edmondson Ave. Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed .O. Box 68760, resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical signed by the attending phys d be detached for use as the IF FEMALE 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificete has t lirector, page 2 s autopsy 2 No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ţ After thi 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending 1 Naturat 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitei 1 Scentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the chase(s) and n. armer as stated.
2 Description Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Conflict Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 6,2005 15204-6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hospital Drive Juite 208 Sten Burne, MD 21061 DR. OCHANES 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 7 2005 SEP 0 Registrar

			For State Registrar	State of Mary	-	ertificate of			ene PNO O O E	20000
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, La Charles 4a. Facility Name (If not institution, give	- Mors	e Sr	1	or Location of Death	2. Date of Death Month	Day Year 29 02 4c. County of Dea	5 11:15 AM
	Funeral Director		Chesapeake 5. Social Security Number 147-24-6654 Usual Residence of Decedent	TWA OFF	yrs. last birthday	Lint (1) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Mar 24,	(ear) 9. Bir	thplace (State or Foreign ountry) ryland
	the Maryland 28a-f show	ector	10a. State 10b. County MD Anne A		City, Town or Lint	hicum		100	China of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or	E D	817 S. Camp Mead	e Road		10f. Zip Code	21090	100	g. Citizen of What C USA	ountry?
920	72 hours after death with the Maryland neturel', or items 23a or 28a-f show dical Exactive count be positived at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
21215-0036	I within jiene.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12		(Giv life.	edent's Usual Occup e kind of work done DO NOT use retire truck dri	during most of worki d)	ng	Sb. Kind of Business transport	•
nd	be filed ntaf Hygi od other event, II	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			acion
Maryland		ဥ	Howard Whiting 19a. Informant's Name/Relationship (10h Mail	in Address (Carret	1	therine		
	ss 1 and 2 s of Health ar item 27 is other treu		Deborah L. Morse 20a. Method of Disposition 1 Burial 2 Cremation 3	2/spouse 20	6505 Ob. Place of Disp			kesville,	75.5 (FE-50)	54
Baltimore,	permit. Page Department of Importent: if any injury or once.		* 4 Donation 5 Other (Specification of Specification of				ess of Facility Omy Board MD 21201		altimore	Street
	Physician /Medical Examiner		25a. Part1. Exter the disease, 5r com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	offications that caused the one cause on each line. a	vic vev	ral fail	,	r respiratory arrest	t,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord or as a						
.O. Box 6	the death certificate y the attending phys ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of de Month	livery Day Year
Д.	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions of		t resulting in the	underlying cause giv	ven in Part I.		_	o the cause of death?
Vital Records,	The ate h page	e Completed	alchdim influtensi 25. Was case referred to medical	W			26. Place of Death		prior to	utopsy findings available completion of cause of 2 No
Division of Vi	Attending Physicien: r death. ector: After this certific by the funeral director,	Certification; To B	examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 28c. Injur	ier: 4 🗌 Nursing Hor		ce 6 Oother (Spe	city) hugi ce
Divis	i or Att after de Direct din by t	ertific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, si pecify)	treet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.	mination and/or i	nvestigation in my c	pinion death occurre	ed at the time date	and place and due	to the causo(s)
)	To the I within 2 To the Complet	M	29b. Signature and title of certifier MMM	mynns)	29c. Licens	e number 14804 Le 134 p	29d.	Date signed (Mont	h, Day, Year)
			30. Name and address of person who Kann M Drage	MO 8028	(Item 23a) (Type Rifchië	Hery Su	te 134 1	anden	a MDZ	1122
•	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 200	32. Registrar's S	Signature	ule				

		•	For State Registrar	State of Marylan		artment of H			giene Reg. No. 2005	29100		
13	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)	Nelso	m	4h Cib. Town	r Location of Day	2. Date of Dea Month	Day Yea	- 4.30 AM		
	Examin Funeral	er	4a Facility Name (If not institution, give to SAMAY 1) 5. Social Security Number 6. September 6.	tan Hospi	tal last birthday)	Bal-	or Location of Dea	8. Date of Birti	4c. County of De	/A		
	Director		Usual Residence of Decedent	M 2D € 90	Yrs.	Months Days	Hours Min	(Month, Day February	7,1915 I	irthplace (State or Foreign Country)		
	he Marylar 8a-f ehow criffed at	ector	10a. State 10b. County Maryland N/A		y, Town or Lo					10d. Inside City Limits 1 □ Yes 2 □ No		
	ath with t	Funeral Director	10e. Street and Number 1651 E Belvedere Avenue	<u> </u>		10f. Zip Code	21239		10g. Citizen of What (USA	Country?		
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinat must be notified at	٥	11. Marital Status 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forsas? 1 ☐ Yes 270 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub.	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wt Specify:	nerican Indian, hite, etc. White		
21215-0036	d within 72 h piene. r than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking	16b. Kind of Business/Industry Private			
Maryland ?	should be filed and Mental Hygic is marked other	To Be C	17. Father's Name (First, Middle, Last) Alfred Bateman			, 4 , 3 , 5		me (First, Middle, en Amanda (Maiden Sumame)			
	1 and 2 sho Health and I tem 27 is me		19a. Informant's Name/Relationship (Ty V. Jane Derry	pe, Print) Niece	-	ng Address (Street Donington C			r, City or Town, State	, Zip Code)		
Baltimore,	0 0		20a. Method of Disposition 1 //Burial 2/2 Cremation 3 F 4 Donation 5 Other (Specify)		Place of Disponentery, cremount (sition (Name of matory or other plai emetery	се) 9/7	Date /05	20c. Location - City of Baltimore,			
Balti	permit. Pag Department Important: I any injury o		21. Spinature of Funeral Sansari Joenson			•			defeld Funera altimore, Mar	al Home Inc		
	Physician /Medical Examiner potential transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	na causa on-mach lina	uence of):		ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death		
P.O. Box 68760,	at the death certificate by the attending phy: tached for use as the	Physician/Medical E	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	I death 3	Ectopic pregnancy Other (specify)	y		23d. Date of d Month	elivery Day Year		
	w requires the been signed should be de	by	Part fl. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.		obacco use contribute es 2 □ No 3 □ I	to the cause of death? Probably 4 Denknown		
Vital Records,		Completed						24a. Was a autop perfor 1 Yes	sy prior to	autopsy findings available occupietion of cause of occupietion of cause of occupies 2 2 No		
Division of Vit	Attending Physician: Trideath. creath. sctor: After this certificet by the funeral director, pa	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor M 1 🗆	ler: 4 ☐ Nursing I	28d. Describe h	ence 6 Other (Sp ow injury occurred			
Divi	o at the		4 Homicide determined	28e. Pface of Injury - At he building, etc. (Specif	y) 			City or Tow				
	To the Hospital or Atteni within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai	one) Medical Exami	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death	vestigation, in my o	ppinion, death occi	urred at the time, o	date and place, and du	ue to the cause(s)		
	o Min o	/	29b. Signation and title of certifier	ME)	29c. Licens	93		29d. Date signed (Mor	nin, Uay, Year)		
1	11		30. Name and dress of gerso who so	W101/1 1 710	1 23a) (Type,	privil N. W.SI	uch 200	5. 10W	in MA 212	oy.		
	Sta Registr		31. Date filed (Month, Day, Year)	32. R. digrar's Signa	iture	Goods						

			1 - For State Registrar	State of M	aryland	d / Depa <i>Cei</i>	artment rtificate	t of He	alth a eath	nd Me		giene	005	29	101
	Physici /Medio	al	Decedent's Name (First, Middle, Last) Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give	G. No	nois	3	45 Cit.	Town, or L			Date of De Month	Day	Year ACO		ne of Death
	Examin Funeral	er	Echos Hopkins Bo 5. Social Security Number 6. Sec	13018W	CoseC	ast birthday)	If Under	no	If Under 2	Love	Date of Bir	th C	County of Deat	DR (Si	ate or Foreign
	Director		579-40-1741	M 2□F	75	Yrs.		Days	Tiodis		(Month, Da	,1930) See	otlan	de City Limits
	the Mary 28a-f sh notified	Director	Maryland N. 10e. Street and Number	/A			10f. Zip	Code		Bal	timor		en of What Co	Ĺ	Yes 2∑No
	h with	i Di	329 Gusryan Str	eet			101124	0040	2	1224			ed Sta		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show item 27 is marked other than "natural", or Items 23a or 28a-1 show othar traumatic evant, the Medical Expressed must be notified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 243 If Yes, Give Year or Dates:	?	1	Was Deced If Yes, spec 1 ☐ Yes 2	rfy Cuban,	anic Orig Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No can, etc.)		4. Race - Ame Black, White Specify:		
21215-0036	rithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Edu (Specify only highest grade		5+)	life.	dent's Usua kind of wor DO NOT us Struc	rk done dui e retired)	ring most			16b. Kin	od of Business/		n
N	12 should be filed within "n and Mental Hygiene." I's marked other than "raumatic evant, the Men	To Be Co	12 Years 17. Father's Name (First, Middle, Last) Charles I. Norri	S		COII				's Name (i	First, Middle, adie E		Sumame)		
Maryland	2 should and Miles mari	-	19a. Informant's Name/Relationship (Ty										Town, State, 2		
ď,	ss 1 and 2 of Health item 27 i		Charlene Broccol 20a. Method of Disposition		20b. P	lace of Dispo	Loal	ne of	re.	Dunaa	alk, M		cation - City or	222 Town, Sta	te
altimore,	permit. Pages 1 Department of H Important: If ite any injury or ot 20028.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signalum of Funeral Service Licens			ly Hil		. Gdr			005	Mid	ddle Ri	ver,	MD
Ba	Depa Impo any ir		Justo a Jones			-	Duda- 7922	Ruck Wise	Fun Ave.	eral Dur	ndalk,	Mary	ındalk, yland	Inc. 21222	2
€0°, <	Physician /Medical		23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart efficient. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of):												
	cate be executed physician and the burial-transit of the burial-tr	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):	ch	(0)	Pul		2014	Disc	2576	yea	∞2
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pro					2	3d. Date of del Month	ivery Day	Year
٥	sign d be	by	Part II. Other significant conditions con	ntributing to death t	out not resu	ulting in the u	nderlying ca	ause given	in Part !.		23e. Did t	,	se contribute to		of death?
Il Records,		Completed	Asbestosis Communica	rteri	Disc	000				_	24a. Was autop perfo		24b. Were au prior to death?	completion	of cause of
Vital	Physician: Th this certificate al director, pag	o Be	25. Was case referred to medical examiner?	lospital: Inpati	ent 201	ER/Outpatier	nt 3 DO	Other			Check only o		G0*b /0	26.3	
ision of	ding h. After fune	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ury	28b. Time of Injury		8c. Injury a Work?		28	d. Describe		Other (Spec	city)	
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Homicide See. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 28d. Describe how injury occurred								ral Route	Number,				
$_{2}$	To the Hospital or A within 24 hours after To the Funeral Directonpletely filled in b	edlcai (29a. Certifier Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner st	of examinat	wledge, death tion and/or in	n occurred a vestigation,	at the time, in my opir	, date and nion, death	place, and	d due to the at the time,	cause(s) a date and	and manner as place, and due	stated. to the cau	use(s)
	To th To th	Me	29b. Signature and title of certifier	7 <		. ^	29c	. License r	number			29d. Date	signed (Monti	h, Day, Ye.	ar)
•	,		30. Name and address of person who co	ompleten cause of	death (Item	23a) (Tuno) \	70,	439	58		Aug	ust 31	1) 50	205
	6		Jenifer Forti	5505 H	Opkin	-2 ODE	Dier	2 Ci	clo	00	Hec	se,	non	Jac	7 133
	Sta Registi		31. Date filed (Month, Day, Year)	2005 A	ar's Signal		Coase								

			For State Registrar	State of Maryland		nt of Health and I te of Death	Mental Hygie	2000	29102
*2	Physicia	an	1. Decedent's Name (First, Middle, Last	· C.	Polum	bo	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give	Kossville		Town, or Location of Death	2		imort
ile	Funeral Director		5. Social Security Number 6. Se 15 Usual Residence of Decedent	X 7. Age (In yrs. I	Yrs. Months		(Month, Day, Y	gar) Co	hplace (State or Foreign untry) RYCANO
	e Maryland 3a-f ehow Hiffed at	Director	10a. State 10b. County MA BALTIN	NORE 100. City		moet			10d. Inside City Limits 1 ☐ Yes 2 No
	e 23a or 20	eral Dire	10e. Street and Nymber Har burg	12. Was Decedent Ever in U.		21237.		Citizen of What Co	•
5-0036	72 hours after death with the Maryland natural; or Itame 23a or 28a-f ehow Jidal Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, spe	dent of Hispanic Origin? (Secify Cuban, Mexican, Puerl	o Rican, etc.)	Black, White	e, etc. Nite-
21	within 72 ho ene then "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de comp <i>leted)</i> College (1-4or 5+)	16a. Decedent's Usu (Give kind of w life. DO NOT	ork done during most of wo use retired)		b. Kind of Business	Industry
Maryland 21	be filed tal Hygi d other	To Be Co	17. Father's Name (First, Middle, Last)	entowski	recour		me (First, Middle, Ma	iden Sumame)	79.
	and 2 should leath and Men n 27 is marke		19a. Informant's Name/Relationship (T	ype, Print)	WHIdel	s (Street and Number or Ri	SALTIMO	RE, MD	21237
Baltimore,	t. Pages 1 tment of H tent: If Iter		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	10 10 10	Faith 9-1	7-05 K	C. Location · City or	e MS
Bal	permit. Departr Importu any inj		21. Signature of Funeral Service Lice	. rather his	FUAN	S FUNERAL C	ALTIMOREE HAPEL-8	5800 HART	FORDIRA: Approximate
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		16		b. Due to (or as a conseq		NIA			
, 00	certificate be executed rding physician and ise as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq					***
68760,	rtificate b ng physic s as the b	Medica	IF FEMALE:	d					
P.O. Box		Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 □Ectopic			23d. Date of de Month	livery Day Year
	- v -		Part II. Other significant conditions of	ontributing to death but not res		cause given in Part I.		-	o the cause of death?
Division of Vital Records,	The taw ate has b page 2 s	Completed by	SESIS				24a. Was an autopsy performe 1 ☐ Yes 2 ☐	prior to death?	utopsy findings available completion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ [ath <i>(Check only one)</i> Home 5 🗆 Residen		erful
ion of	ng Phy fter this meral d	ation: To	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how		ony
Divis	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	24 hou Funer etely fill	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and plac on, in my opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		2	9c. License number	290	d. Date signed (Mon	th, Day, Year)
	/			43)		DS\$306	32	17,6	2005
	15		30. Name and address of person who DENNIS HODGE	9106 PHCAI	well than fo	Suise	200, Bo	OH ON	31237
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 26,2005 VIOLA LLOA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 8, 1921 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 T Yrs. 425-84-6256 84 Cohoma, MS Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Baltimore 1 ☐ Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 4 Yardly Court USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. Black. 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jesse Sheley Hattie Hessler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Yardly Ct. Baltimore, MD (Daughter) Margarette Craig 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9 - 3 - 05Ruleville, MS Turner Chapel Cem. `4 □ Donation 5 □ Other (Specify) 21. Signature/of Funeral Service License 22. Name and Address of Facility Byas Funeral Home 407 Front St. Indianola, MS 38751 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/MedIcal IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🏋 No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 3 DOA this 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 2 🗌 No after death 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ichla 12005 26 Dooyihio August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1061MOER P MEHTA CENTER BANDAUSTOWN MD TRAMMEST JAT 1920H 32. Redistrar's Signature 31. Date filed (Month, Day, Year) 7 2005 Registrar SEP 0

DHMH 17 Rev 1/2001

PFEIFER, JOHN 1 09.06.

	1	1- State of Maryland / Department of Health and Certificate of Death	Mental Hy	reg. No. 2005 29105
Physiciar /Medica Examine	r r	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea 4730 Tjamsville Road 5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hr.		County of Death Frederick
Funeral Director		217-46-1918 1™ M 2□ F 58 Yrs. Months Days Hours Min Usual Residence of Decedent		28, 1947 Maryland
or 28a-f show	lrector	10a. State 10b. County 10c. City, Town or Location MD Frederick Tjamsville 10e. Street and Number 10f. Zip Code		10d. Inside City Limits 1 ☐ Yes 2 ☒ No 10g. Citizen of What Country?
permit. Pagas 1 and 2 should ba filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked othar then "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Medical Expir an marker conditied at once.	by rur	4730 Tjamsville Road 21754	Specify Yes or No into Rican, etc.)	United States 14. Race - American Indian, Black, White, etc. Specify: White
d within 72 ho giene. ir then "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 15. Decedent's Education (Give kind of work done during most of work done	orking	16b. Kind of Business/Industry Painting
chould ba filled to Mental Hygmarked othar matic event.	lo Be C		is Picke	
agas 1 and 2 s ant of Health an ht: If item 27 Is y or other trau		Gail Reed Sister 7151 John Pickett Roa 20a. Method of Disposition 20b. Place of Disposition (Name of		oine, MD 21797 20c. Location - City or Town, State
permit. Pagas 1 a Department of Hee Important: If item any injury or othe snce.		21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Fun 1212 W. Old Liber	neral Hom	Sykesville, MD ne & Crematory, P.A. winfield, MD 21/84
te be ysicié	Ical Ex	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if all y, it laung to train solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ure	Approximate Interval Between Onset and Death
ires that the death certifical signed by the attending phid be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
The law requate has been page 2 should	Completed	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	24a. Was	psy prior to completion of cause of death?
ding Phy After this funeral d	ation: To Be	25. Was case referred to medical examiner? 1		idence 6 Other (Specify) how injury occurred
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte compiletely filled in by the funerel.	Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	(Street and Number or Rural Route Number, wn, State)
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated. 29b. Signalare and title of certifier 29c. License number	ce, and due to the curred at the time.	cause(s) and manner as stated. date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
E 3 E 8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		9/6/2005
State Registra	₹ 1	31. Date filed (Month, Day Year) 7 2005 32. Registrar's Signature	Va Dr.	ve Site TOL Frelmo

			State of Maryland / De State of Maryland / De 23a per Dr., G847	partment of Health and I 09/07/05dhb ertificate of Death	Mental Hygier	ne2005 29106
		**	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year 3. Time of Death
	Physici /Medic		Charles A. Peacock		August	26 2005 11:30PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			5. Sociel Security Number Sd. Sex 7. Age (in yrs. last birthda	KOSCOQY If Under 1 Year If Under 24 Hrs.	9 Date of Righ	Daltimore
	Funeral Director		218-30-6241 1X M 2 F 69 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes July 13,	ar) 1936 9. Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent		Jacy 13;	
	r 28a-f show	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director	Maryland Baltimore	N/A		
	with t		10e. Street and Number	10f. Zip Code	log.	Citizen of What Country?
	ir death with tems 23e or er must be	Funerai	2240 Graythorn Road 11. Marital Status 12. Was Decedent Ever in U.S. 1	21220 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	U. S. A. 14. Race - American Indian,
ယ	after or iter	표	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ YNo		o Rican, etc.)	Black, White, etc.
03	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-1 show he Medicul Erain ar must be redified at	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: White
5-6	"natu	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wor a. DO NOT use retired)	king 16b	. Kind of Business/Industry
12	withir ene. than	dmo	Elementary/Secondary (0-12) College (1-4or 5+) "" 12th Grade	Carpenter		Contracting
9	be filed withintal Hygiene. Id other than event, the M	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
Maryland 21215-0036		To B	Charles H. Peacock	н	elen T. Ha	vris
ary	" = m =		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ailing Address (Street and Number or Ru	ral Route Number, Cit	ty or Town, State, Zip Code)
	1 and 2 Health a em 27 Is			0 Box 424, Thomas		
Baltimore,			20a. Method of Disposition 1 20b. Place of Discometery, of Communication 3 □ Removal from State	sposition (Name of rematory or other place)	Date 20c.	. Location - City or Town, State
Ë	tment tent:		° 4 Donation 5 Other (Specify) Garden	s of Faith 8/31	/2005 Bo	ultimore, Maryland
Bal	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sc 3331 Brehms Lane,	himunek Fu Baltimore,	neral Home Inc. <u>Marylan</u> d 21213
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac ph Pneumonia	or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician	4	Immediate Cause (Final disease or condition resulting in death)	1 tallet€		Criser and Dealin
	/Medical Examiner		Due to (nr as a consequence of	1 50		
	uted d ansit	i i	Sequentially list conditions, b. Sura to (or as a consequence of)	TITOTE		
		Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Ć,	execut an and rial-tra		resulting in death) Last Due to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	dicai	d			
9	ng ph	Med	IF FEMALE:			
Вох	eath certific attending p	lan/l	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 Ectopic prégnancy		23d. Date of delivery Month Day Year
	the a	by Physician/Me	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 Other (specify)		
P.0	that the de ed by the detached	Ph.	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ds,	uires tha signed Id be de	d b			1 ☐ Yes	2 No 3 Probably 4 Unknown
CO	w require been sign	Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Re	The lav	duic			autopsy performed	? death?
ta	sicien: Th certificate rector, pag	a)	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 th (Check only one)	NO I Tes 2 No
Ž	Physicien: this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor		6 ☐Other (Specify)
Division of Vital Records,	ding PI h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injur		28d. Describe how in	njury occurred
	ttendi death. ctor: A / the fu	cati	2 Accident investigation	M 1 Yes 2 No		
Νį	or Ati	Certification:	4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
-	ours sours source sou		29a. Certifier 1 Certifying Physician: To the best of my knowledge, di	eath occurred at the time, date and place	and due to the cause	a(s) and manner as stated
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending promptetely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examiner: On the basis of examination and/o one)	r investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			long line	D63216	(08/06/05
			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	11	14410
	* * *		31. Date filed (Month Day, Year) 32. Registrar's Signature	square Drive by	altimore	MU. 21337
:	Sta Regist	ate rar	SEP 0 2 2005	•		
		1- 8	001 0 10 2000	Ana St.		

DHMH 17 Rev 1/2001

ORIGINAL

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2005 29107
Physician /Medical	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year September 4, 2005 3. Time of Death 2:45P
Examiner	4a. Facility Name (If not institution, give street and number) Gilchrist Center 4b. City, Town, or Location of Death TOWSON Baltimore
Funeral Spirector	5. Social Security Number 057-07-8424 6. Sex 1 Age (In yrs. last birthday) 1 M 2 XX 92 Yrs. 1 Months Days Hours Min. Months Days Hours Min. Months Days Hours Min. 9. Birthplace (State or Foreign Months) New York
Maryland e-f show filled at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Towson 11 Yes XXXX
with the	10e. Street and Number 10f. Zip Code 10g. Cilizen of Whal Country? 204 East Joppa Road 21286 USA
21215-0036 ed within 72 hours after death with the Maryland sylene "natural", or items 23s or 28s-1 show it, tra Medical Examinar must be notified at Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, While, etc.) 14. Race - American Indian, Black, While, etc. 1
21215-003 4 within 72 hours giene Tratural; tre Medical Exi	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary Communications
Vland 2 vuid be filed Mental Hygi arked other stic event, II	17. Father's Name (First, Middle, Last) William Edward Rice 18. Mother's Name (First, Middle, Maiden Sumame) Mable MacMullan
Maryland 2121 nd 2 should be filled within tith and Maheral Hygiest 27 is marked other then- rtraumatic event, tramss To Be Compli	19a. Informant's Name/Relationship (Type, Print) John A Buonomo Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 159 West Lancaster Avenue Paoli Pennsylvania 19301
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours all Department of Health and Mental Hygiene. Important: if itam 27 is marked other then "natural", or eny injury or other traumatic event, the Medical Exercipance.	20a. Method of Disposition X X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Dulaney Valley Mem Gardens 20c. Location · City or Town, State 20c. Location · City or Town 20c. Location · City or Town 20c. Location · City or Town 20c. Location · City or Town 20c. Location · City
B760, are be executed American and the burial-transit stream Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. The planting to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
LRecords, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examilia	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
dS, P. dS, P. dires that the signed by doe detacted by Phy	Part II. Other significant conditions commonly to death but not resulting in the underlying cause given in Part I.
I Record I Record The law requir page 2 should	24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \ 2 \text{No} \] 1 \[\text{Yes} \ 2 \text{No} \]
on of Vite ding Physician b. A Aler this certific fundral director funds of 100: To Be	25. Was case referred to medical examiner? 1 Yes 2 No
Hospita Hours Funeral	
To the within 2 To the comple	DC3202 Cools of 42005
(V	30. Name' and address of person who completed cause of death (Item 23a) (Type, Print) AALON CHARLO NO (GOO) N. MANUL ST TOWN MP 21 20 9 31. Date filed (Month, Day, Year) 7 200532. Registrar's Signature
State Registrar	31. Date filed (Month, Day, Yeer) 7 20032. Registrar's Signature

Certificate of Death

4b. City, Town, or Location of Death

Timonium

For State Registra

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

Leo William Rader

Stella Maris

14. Race - American Indian, Black White etc. White Specify: 16b. Kind of Business/Industry Leo W. Rader Surveyors, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. Sept. 07, 2005 Rossville, Maryland Peaceful Alternatives Funeral&Cremation Ctr., P.A. 21093 2325 York Road Timonium, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 26. Place of Death | Check only one) 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, doubt account of the cause(s) and manner as stated. iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 TO SE

Reg. No 2005

4c. County of Death

Baltimore County

5:50 P. M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

September 2005

2. Date of Death

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIO MAHMOOD

7 2005

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#2, perMD, G84/ 9/7/05 TT

State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year **Physician** ACHE GB11050N 4419 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ABINGDON UNII MILLE HARFORD 3 WIN If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours 215.28.0741 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🗷 No Director ARFORI 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code CT. UNIT Completed by Funeral Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AURORA VENERE VITALE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 100 9 203 WINDMILLE CT. UNIT ABINGDOW, MO EON KOBINSON · HUSBAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BELAIR MEMBRIAL KEL *4 Donation 5 Other (Specify) Estembrent AIR 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FWERAL CHAPEL -BLAIL M01220 FOREST HILL, ND 21050 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mort Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 DNo 24a. Was an autopsy 1 ☐ Yes 2. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Certification: To 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home Sesidence 6 ☐ Other (Specify) 27. Manner of Death 1 Matural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔽 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The law requires that the death certificate be executed burial-transit the attending physician and Division of Vital Records, P.O. signed by has been certificate this After or Attending death Director:

use as the for detached should be page 2 funeral director. the filled in by within 24 hours after To the Funerel Direct completely the

Funeral

Director

Items 23a or 28e-f ehow

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"naturel".

d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "ne

Pages 1 and 2 should be nent of Health and Mental

item 27 i

permit. Pages Department of I Importent: If its any injury or o once.

Physician

/Medical Examiner

other

treumatic event, the Medical Examiner must be notified at

72 hours after deeth with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medicai

(Check only onel

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number D456++

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

AUGUST

ho completed cause of death (frem 23a) (Type, Print) Name and address of

2005

RUMTREEM, SUITE 115,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Year 5 Physician 3:30P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) do 5. Social Security Number 9 (101) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 1 F 219.50.5835 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow must be notified at AUTIMORE 1 Yes 2 □ No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 2519 21213 or Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Mudical Examiner 2 Married 1 Never Married permit. Pages 1 and 2 should be filed within 72 hours at. Depertment of Health and Mental Hygiens. If them 27 is marked other than "nature!", or lany injury or other traumatic event. Its example 100.00. 2 No by If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide, Be ္ပ 19b. Mailing Address (Street and Number or Rural Route MOTTH 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 9.10.05 BALTIMORE, MARYLAND OUDON 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERING HM ROAD BAITIMORE, MARYLAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atraclania Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 2 100 Inpatient Jo 1 Tes 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death
Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours after death. here! Director: After this certificete has been signed by the etter filled in by the funeral director, page 2 should be detached for i To the Hospital or within 24 hours afte To the Funeral Die

Baltimore, Maryland 21215-0036

10

Medicai

29a. Certifier

(Check only one)

29b. Signature and title

Registrar

DHMH 17 Rev 1/2001

r. Jones Welkel yare Orive Baltimol ronklin Sq 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

M2025007

29d. Date signed (Month, Day, Year)

			1_ For State	State of Marylan	nd / Departi	ment of Health and	•	•	29111
			Registrar 1. Decedent's Name (First, Middle, Las	11	Cenii	icate of Death	2. Date of Death		3. Time of Death
	Physici /Medic	cal	Trankje t	Tancine	KODI	City_Town, or Location of De	Solenin	Day Year 4c. County of Death	692 DM
1	Examir	ıer	Union Men	norial Ho	Spital	Baltim	ore	4c. County of Death	
	Funeral Director	1	5. Social Security Number 6. Security Number 11	ox 7. Age (In yrs. 55		Under 1 Year I on this Days Hours M	Irs. 8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign intry)
	iand ow	0	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Location	on		717	10d. Inside City Limits
	Be-f sh	Director	MD	F	Baltin	nore			1 Yes 2 □ No
	death with the Maryland rms 23a or 28e-f show r trust be notified at	al Dire	106. Street and Number	St Street	+ 1	of. Zip Code	10g.	Citizen of What Cou	intry?
	Items	Funekal	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was	Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White,	
5-0036	72 hours after naturel', or ite	b	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:		Yes No Specify:		Specify: B	lack
215-	within 72 ene. than "nat	Completed	15. Decedent's Ed (Specify only highest grad Elementar/Geophtary (0-12)	ucation de completed) College (1-4or 5+)	(Give kind	s Usual Occupation for work done during most of a NOT use retired)	vorking . 16b.	. Kind of Business/Ir	Paro 1
21	filed with Hygiene. other thai	e Con	17. Father's Name (First, Middle, Last)		14ur	18. Mother's N	lame (First, Middle, Maid	den Sumame)	
Maryland	should be and Mental marked o	To Be	Frank-Peri	φ .		Hi/	da Cot	HON)
, Mar	01 00 00		Vanessab.	horis	19b. Mailing A 27/2	ddress (Street and Number or Halcuou	Ace R	ty or Town, State, Zip	Code)
Baltimore	ages 1 and 2 nt of Health t: If item 27 I f or other tre		20a. Method of Disposition Burial 2 Cremation 3	Removal from State	Place of Dispositio cemetery, cremato	n (Name of ry or other place)	9/10/95 R	Location - City or To	own, State
altir	permit. Page Department o Importent: If any injury or once.		'4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen.	11.70	SXX IAW	me and Address of Fac.	Fru Fru	20 17 L SO	roices
	405 6 3		23a. Part 1 Enter the disease, or comp	olications that caused the death	h. Do not enter th	905 Jak e mode of dylng, such as card	d Balto iac or respiratory arrest,	MO ZIZ	Approximate
B	Physician		Immediate Cause (Final disease or condition	a. Acy c.	Mrelo	ierous 1	eyten	4	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence f):	, ,,			
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence)	uence of):				
,00	eath certificate be executed attending physician and for use as the burial-transit	Exar	that initiated events resulting in death) Last	cDue to (or as a consequence)	uence of):				
68760	ificate b g physic as the b	edical	•	d					
Вох	attendin for use	Physician/Med	in the past 12 months?	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	I death 3 □Ect	ppic pregnancy		23d. Date of deliver	ery Day Year
P.O.	res that the de signed by the a be detached f	hysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9☐ Unknown		ner (specify)			
	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant conditions of	entributing to death but not resu	ulting in the under	lying cause given in Part I.		o use contribute to to	he cause of death?
Records,	ne law requir has been si ge 2 should	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
Vital R		a)	25. Was case referred to medical			26 Place of F	performed' 1 Yes 2 Death (Check only one)		2 No
of Vi	Physiclen: this certific ral director,	To B	examiner?	Hospital: Inpatient 2	ER/Outpatient 3	Oth	Home 5 Residence	6 ☐Other (Special	(y)
o uo	ling h. After lune		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street,	factory, office	28f. Location (Street City or Town, Str	and Number or Rura ate)	al Route Number,
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying Phy	vsician: To the best of my kno iner: On the basis of examina	wledge, death occ	curred at the time, date and pla	ce, and due to the cause	(s) and manner as s	stated.
	o the H rithin 24 o the F omplete	Medical	29b. Signature and title of control	and manner stated.	tion andor investi	29c. License number		and place, and due to Date signed (Month,	
	- s + ō		11/19	M-D		1494V			9
	N		30. No e a address of persod who co		23a) (Type, Print	worth Calu	+ SREOT	B-11	MJ ZAJY
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regiŝtrar's Signa		W. 6	V - 100 .	- 1 /100000	J IO SHOTS
-	Registr	ar	SEP 0 72	1115	PS DOS				

DHMH 17 Rev 1/2001

Physician /Medical Examiner 4a. Facility Name What stitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death Funeral Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10c. City, Town or Location 10d. Inside	
Funeral Director Usual Residence of Decedent 4a. Facility Name (Liber Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County of Death	
Funeral Director Usual Residence of Decedent S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Sta Scurity) 9. Birthplace (Sta Scurity) 1	e or Foreign
100 City Town or Localing	
10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 10g. Citizen of What Country? USA	City Limits
E RI TO THE CALLER TICITED LAGO USA	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc.	,
1 Never Married 2 Married 1 Yes 2 No II Yes, Give 1 Yes, Give 1 Yes, Give 1 Yes Constitution 1 Specify: Specify	
1 Never Married 2 Married 1 1 Yes 2 No 1 Yes, Specify 1 Yes 2 No 1 Yes, Specify 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2 Yes Yes or or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 16b. Kind	,
The state of the s	<i>→</i>
ROSCOE KUDIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rulal Route Number, City or Town, State, Belode) ROGER RUDIN (SON) 1531 WINSTON AVENUE BLOOM)	1129
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State	
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place) 20c. Location - City or Town, State camelery, crematory or other place)	es
	nate Between nd Death
Physician (disease or condition resulting in death) Examiner Physician (disease or condition resulting in death) Due to (or as a consequence of): Left Lung Pheumonia	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
figure 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oil): Due to (or as a consequence oil): Due to (or as a consequence oil): Due to (or as a consequence oil):	
Due to (or as a consequence of): We describe the second of the second o	
23d. Date of delivery 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	Year
Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4	
The state of the s	is available cause of
25. Was case referred to medical examiner? 1	
The state of the s	
28a. Date of Injury 28b. Time of Injury 28c. Injury al Work? 1	ımber,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year	∍(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
MOHAMMED. G. KIDDUGMU, Maryland Gen Hospital 827 Linder Av Bain State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	wast wil

				L State	laryland / Departm	nent of Health and cate of Death		2005	29113
		* *** * ·	16	Registrar 1. Decedent's Name (First, Middle, Last)	Certinic	ale of Dealif	Reg. I		3. Time of Death
_		Physici /Medi		Philip Joseph	Smith		Soot	2 2005.	4551.M
		Examir		4a. Facility Name (If not institution, give street and number,) 4b. (City, Town, or Location of Dear	h	4c. County of Death	
200	,	Funcial	. 35			INON UM	8. Date of Birth	9 Birthola	ace (State or Foreign
5	- 3	Funeral Director		034-16-4206 1×M 20F	76 Yrs. Mon	nths Days Hours Min	(Month, Day, Year 9-10-25	ar) Countr	ACHUSETTS
5	-	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	1	•	10	d. Inside City Limits
7		Maryli -1 sho	tor	MD BALTIMORE	Cocke	ysville			1 Yes 2 No
1		within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-1 show ha Modical Exertinal te notified at	Funeral Director	10e. Street and Number	101	Zip Code	10g.	Citizen of What Count	ry?
5		s 23a	rai	409 Laiu Vi Sta Cir. Hot	Everin II S 12 Wee F	21030	Coopin Vac or No	14. Race - America	n Indian
0	(0	fter de	Fund	1 Never Married 2 Married 1 Yes 2	(No	Decedent of Hispanic Origin? (S , specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, et	
2	21215-0036	ours a	d by	3 ☐ Widowed 4 Divorced If Yes, Give Year or Dates:		es 2 No Specify:		Specify: Whi	16
~	15-(n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind o	Usual Occupation of work done during most of wo OT use retired)	rking 16b.	. Kind of Business/Indu	ustry
18	212	d withi	omo	Elementary/Secondary (0-12) College (1-4or	Salesn		n	larketin	C
7	nd	be filed tal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid	en Sumame)	1
100	Maryland	should be filed with nd Mental Hygiene, smarked other that umatic event, the new that the second that the seco	2	19a. Informant's Name/Relationship (Type, Print)	10h Mailing Ada	dress (Street and Number or R	LS L. C	straug r	noda)
tember	Mai	ges 1 and 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. It if itam 27 is marked other than "netural", or items 23a or 28e-f show or other traumatic event, the Modical Exertimer Intest to notified at		Jeinifer S. Leineweber		na lourerest	H. Edwer	and MD	21040
to	ore,	of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Disposition	(Name of	Date 20c.	Location - City or Tow	vn, State
3	Baltimore,	Pages ment of I tant: If its		4 □ Donation 5 □ Other (Specify)	Evens Funcial			crest Hill	I MP
M	Ball	permit. Pages 1 and 2. Department of Health at Important: If Itam 27 is eny injury or other tratonce.		21. Signature of Funeral Service Licenses	22. Nam	ne and Address of Facility	loizk ED.	Timen.un	110204
	<4.	- K **X		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	the death. Do not enter the	mode of dying, such as cardia	OVESTUNE c or respiratory arrest,		Approximate
		Physician		Immediate Cause (Final disease or condition	nhageal C	ancer		,	Interval Between Onset and Death
		/Medical Examiner		reculting in death)	s a consequence of):	.,,			
	*	LAMIIIII	7.0	Sequentially list conditions,	S & Consequence of).				
,	10/	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,				
	, 0°	ate be executed hysician and the burial-transit			s a consequence of):				
	Box 68760,	the by	dicai	d					
	9 X	death certific e attending p od for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom		·		23d. Date of deliver	y
~	B	the atter	by Physician/Me	in the past 12 months? 1 Yes 2 No		pic pregnancy ar (specify)		Month E	Day Year
1	P.0	that the death ed by the atte detached for	Phys	9 ☐ Unknown Part II. Dther significant conditions contributing to death	hus not requising in the constant.	diameter in Dark I	22a Did tahaan	o use contribute to the	a cause of death?
1		The law requires that the Ite has been signed by th page 2 should be detache	d by	Part II. Dither significant conditions continuing to death	but not resulting in the underly	ong cause given in Part I.	1 ☐ Yes		1
m	COL	w requ	lete				24a. Was an	24b. Were autop	sy findings available ipletion of cause of
V	of Vital Records,	The lav	Completed				autopsy performed 1 ☐ Yes 2 △	? prior to com death? No 1 \(\sum \) Yes 2	
	/ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			ath (Check only one)		1
2	of	or Attending Physician: filer death. Director: After this certifici in by the funeral director, i	- To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpat 27. Manner of Death 28a. Date of Inj			Home 5 Residence		Hospice
	ion	nding F th. r: After e funer	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ay Yeer) Injury M	28c. Injury at Work? 1		, , , , , , , , , , , , , , , , , , , ,	
7	Division	I or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Ir building, €	njury - At home, farm, street, fa	actory, office	28f. Location (Street City or Town, St	t and Number or Rural tate)	Route Number,
9		To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funaral Director: After this certificate has been signiconneciety filled in by the funeral director, page 2 should be		29a. Certifier 12 Certifying Physician: To the bes	t of my knowledge, death acco	urand at the time date and place	a and due to the source	-(a) and manner on etc	tod.
		To the Hospital o within 24 hours af To the Funaral Di completely filled is	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manner s	of examination and/or investigation	artion, in my opinion, death occ	e, and due to the cause urred at the time, date a	and place, and due to	the cause(s)
_		To th within To th comp	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	Dey, Year)
		- 1.1		1-		D43721	00	10305	
		711		30. Name and address of person who completed cause of	death (Item 23a) (Type, Print)	laneu Valla	u Rel Ti	imonium	Md21093
	14.	St St	ate	31. Date filed (Month, Day Year) 32. Regis	trar's Signature	Trested occup		71101110711	
		Regist	rar	SEP 0 7 2005	J.S. Marine				

			For State Registrar	State of N	Naryland /		artment <i>tificate</i>			ınd M		giene Reg. No.	/ 111)5	29114
			1. Decedent's Name (First, Middle,	Last)			-				2. Date of Dea Month	ath Day	, ,	rear	3. Time of Death
	Physicia /Medic		Ruth	J		51	WITH				Augu ST	28		005	11:51 AM
	Examin		4a. Facility Name (If not institution,		r)		4b. City, 7	Town, or	Location o	f Death	, , ,	4c.	County o	Death	
	h.		The Johns Hori		aL	- 1-44 - 4- 1	If Under		If Under 2	CI	TY	<u> </u>		o Birth I	
	Funeral		5. Social Security Number 208-18-5531	6. Sex 7. / 1 ☐ M 2 ☐ ▼F	Age (In yrs. last t 80	Yrs.	Months	Days	Hours	Min.	8. Date of Birt Month, Day May 12	Year)	25	9. Birtingi Count Penn	ace (State or Foreign ry) Sylvania
h	Director	-	Usual Residence of Decedent												
	yland how		10a. State 10b. County		10c. City, To	wn or Lo	cation							10	d. Inside City Limits
	Ba-fe	ctor	MD		East	n									1 Tes 2 No
	or 26	Director	10e. Street and Number	11,205			10f. Zip					-	zen of Wi	nat Coun	try?
	s 23a	ral	700 Port Street		. 5 1- 11 0	140.1		21601		-:-2 (0		USA	14. Race	Amaria	a ladica
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Itam 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Eraninal must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Force ed 1 Yes 2 G If Yes, Give 4 Year or Dates	s? ₹No X		was Decedon f Yes, speci 1 ☐ Yes 2		spante Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			White, e	etc.
Š	2 hou	ted	15. Decedent	s Education	16	a. Dece	dent's Usua	Occupa	ition	n f wande		16b. K	nd of Bus	iness/Ind	ustry
215	within 7 ene. than "n	ple	(Specify only highes. Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	kind of won DO NOT us	e retired,	uring most)	OF WORK	ng				
2	filed wit Hygien other the	Completed	Elementary/Secondary (0-12)			Home	emaker	-)wn H		
Maryland 21215-0036	d be fill ental Hy ced oth c even	To Be	17. Father's Name (First, Middle, L Raymond Erlache								(First, Middle, Christ		Sumame)	
ar _y	2 should be and Mental is marked aumatic ev	Ĕ	19a. Informant's Name/Relationsh	ip (Type, Print)	19	9b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	I Route Numbe	r, City o	r Town, S	tate, Zip	Code)
	s 1 and 2 of Health a Itam 27 is other train		Ethan A. Smith,	Jr. (Hu	sband)	700) Port	St	#42	05	Easton,	MD	216	01	
ore,	of He of He Itam		20a. Method of Disposition 14 Burial 2 Cremation	2 Domeyol from Sta	ceme	tery, crer	sition (Nam	her place	9)		Date		cation - C		
Ē	Page ment ant: th		' 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Geths	semar	ne Cem	neter	ry ¦	9-6-	05	Read	ling,	Pen	nsylvania
Baltimore,	permit, Pages 1 Department of H Important: if Ita any injury or ot		21. Signature o Funeral Service L	specific de la constitución de l	QQ2	22	2. Name and He 2.2	Addres 29 N	s of Facilit nger . 5th	Fune Str	ral Hom eet Rea	e ding	g, PA	. 19	601
			23a. Part . Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death. B	o not ent	er the mode	of dying	g, such as	cardiac o	or respiratory ar	rest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Cerek	val Her	nia	Tien							-31	4 Days
	/Medical Examiner		resulting in death)	Due to (or a	as a consequenc	e of):									, .
		-	Sequentially list conditions,	V. Carlotte Control of the Control o	carrial	Den	tecrha	ige						5	DAYS
Т	rted nslt	Examlne	if any, leading to infraediate cause. Enter Underlying Cause (Disease or injury	KATE AND	A-ic the	4436	Contra	100	veino					1 5	2 Hars
Ć.	execu in and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to (or a	as a consequenc	e of):	CCII	- 60	, , , , , ,	FICE					-,00
8760,	cate be executed physician and s the burial-transit	dical		d											
9	ng ph	Med	IF FEMALE:			-									
Вох	death certificate be executed e attending physician and td for use as the burial-transit	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea		Ectopic pre						23d. Date Mont		ry Day Year
0		ysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown	at time of death	5 L	Other (spe	ecify)							
σ.	res that the igned by be detact	/ Ph	Part II. Other significant condition	ns contributing to death	but not resulting	g in the u	nderlying ca	iuse give	n in Part I.		23e. Did to	obacco i	ise contrit	oute to th	e cause of death?
ds,	requires that the been signed by th hould be detache	d by									1 🗆 🗅	res 2	□ 1√0 :	Prob	ably 4 Unknown
Vital Record	> 1 0	Completed									24a. Was		24b. W	ere autor	osy findings available
Re	The fav	ошь										ssy rmed? 2 ᡌ No	de	ior to con ath? ⊒Yes	npletion of cause of
ital	lan: 'rriffica ctor, p	ø	25. Was case referred to medical		/				26. Place	of Deat	Check only o				
of V	ysic is ce dire	To B	examiner? 1 ☐ Yes 2 █ 10	Hospital:	atient 2 ER/	Outpatier	nt 3 00	A Othe	er: 4 □ Nu	rsing Ho	me 5 🗆 Resid	dence	6 □Othe	(Specify)
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of li (Month, i	njury 28t Day Year)	. Time o Injury		8c. Injury Work	(?		28d. Describe I	now injui	y occurre	d	
sio	or:	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ot be	laiva. At home	60	М		res 2□	No	28f Leastine /	Stmot or	d Numbo	e or Puro	Route Number,
Division	i Sir e	Certification:	4 Homicide determi	ned 28e. Place of building,	Injury - At home, etc. (Specify)	rann, su	reet, ractory	, оптсе			City or Tov			or nura	noute Number,
	To the Hospital within 24 hours a To the Funaral completely filled		29a. Certifier 1 Certifyin	g Physician: To the be	st of my knowled	ige, deat	h occurred	at the tim	ie, date an	d place,	and due to the	cause(s	and man	ner as st	ated.
	the Hi in 24 he Fu pletel	edical	one)	Examiner: On the basis and manner	stated.	and/or in				in occuri					
	To the P within 24 To the F complete	Σ	29b. Signature and title of certifier				3.5		number			29d. Da	te signed	(Month, I	Day, Year)
)	15	1		5				006	204	3_		Augu	15-	28th	2005
1	10		30. Name and address of person	who completed cause of	of death (Item 23:	a) (Type,	Print)	1.10	-		0	A A co	415	2	287
V	Sta	10	31. Date filed (Month, Day, Year)	32. Figure 32.	strar's Signature	OC	B. D	000	re	>7	BaiTiM	ere	MD	41	-0-7
	Registi		SEP 0	7 2005	sur D	S A	10842	A STATE OF THE STA							

State of Maryland / Department of Health and Mental Hygier 0.5For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mable Mozella Steele August 31, 2005 3:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year April 5, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 □ F 250-38-4622 Director 88 1917 South Carolina Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 28e-f show 10d. Inside City Limits other treumstic event, the Medical Examiner must be notified at MD Prince George's Director Camp Springs 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 6810 Coolridge Road Items 23s 20748 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 7 Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Heatth and Mental Hygiene. Int: If item 27 Is markad other than "naturel", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alex Pyos Bertha Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is sny injury or other tre once. Margaret Chambers (Daughter) 6810 Coolridge Road Camp Springs, MD 20748 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Morning Glory Cem. 9-5-05 `4 ☐ Donation 5 ☐ Other (Specify) Georgetown, SC 21. Signature of Funeral Service (Licensee 22. Name and Address of Facility
Wilds Funeral
130 Merriman R is Funeral Home Merriman Rd. Georgetown, SC Home 23a. Part. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The taw requires that the death certificate be executed use as the burial-transit to for as a consequence of) Box 68760, nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autoosy perform 1∐ Yes 2 🗌 No Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) Certification: after death. | Director: After ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo the 6 Could not be determined 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerel C Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 the 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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n			State of Maryl State Unpend Item 23a,pt.II,27	and / Depa	artment of F	lealth and M 47~9#h13-05	lental Hyg 5 tas		5 29116
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_	/Medic		DANIEL DI	VOTR	T		August		05 1:08 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of De	ath
			Frederick Memorial Hospital		Frede			Freder	
7	Funeral			yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	Country) 10 h
9	Director		214-06-1932	Yrs.			100 10,	1973	MAS
9	D		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	antian .				10d Incide City Limits
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	e Ma	cto	MD NIA	/	BALTIMO	Re			THES ZLING
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	within 72 hours after deeth with the Maryland ene. then "natural", or Iteme 23e or 28e-f show he Medical Expiriter must be invilled at	Funeral Director	2877 ROSELAUN A	rve		21214		U.S.	A
	eep .	ner	11. Marital Status 12. Was Decedent Ever Armed Forces?	n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - An Black, Wh	nerican Indian,
9	or lt	臣	1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 No	Specify:			1 -
8	ours	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		12 103 ,23110	эроспу.		Specify:	white
5	72 h natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	oation during most of work	ina	16b. Kind of Busines	s/Industry
21	thin	du	Elementary/Secondary (0-12) College (1-4or 5+)	life.		during most of work d)			4 0 - 0
2	Agier Fr	Ö	12th NA		Wachini	ST		DOTAR	CUP CORP.
9	A CHA	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
la a	Vient Ment wrked urice	일	JOSEPH HOLLAR JR			LAURA	5ING	er.	
Maryland 21215-0036	sho and smu		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State,	, Zip Code)
	alth 27 I		JOSEPH HOLLAR JR	282	2 ROSELA	WN AVE	BAlto.1	40 2121	4
9	S 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1 8 1			b. Place of Dispo			Date 2	20c. Location - City of	or Town, State
Ę	Page ent o nt: If y or		1 ☐ Burial	A 5	Clemer	9/2	105	Bolto M	. 5
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee			ss of Facility	II. Fun	-RAI 1+0M	CHD.
ã	Den Per		Vaulon Street		527 har	FORD RD.	RALL	eral HOM. 21.	224
			33a. Part1. Enter the disease, or complications that caused the						Approximate
			strock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		adone Int	oxication	1		
	Examiner		Due to (or as a cor	sequence of):					
		_	Sequentially list conditions, and any, leading to immediate b.	nervenno offi-					
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Bo	ath c	lan	in the past 12 months?	Fetal death 3 ☐	Ectopic pregnancy	1		23d. Date of d	elivery Day Year
	the the	Sic	1 Yes 2 No 4 Pregnant at time 9 Unknown	or death 5L	Other (specify)				
σ.	Attending Physician: The law requires that the death certifical or death. r death. ector: After this certificete hes been signed by the ettending phy by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medi	Part II. Other significant conditions contributing to death but not	resulting in the u	ndorhina causa au	on in Part I	23a Did tob	acco use contribute	to the cause of death?
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5	requ	tec					10,10	3 2010 001	
ec	law les b	ple					24a. Was ar autops	/ prior to	autopsy findings available completion of cause of
<u> </u>	The ete h page	5					1. Yes 2	ned? death?	es 2 No
ita,	strific ctor,	Be (25. Was case referred to medical examiner?			26. Place of Deatl	h (Check only one	9)	
<u></u>	nyeic li dire	2	1 No Hospital: 1 Dispatient	2X ER/Outpatier	nt 3□ DOA Oth	ner: 4 ☐ Nursing Ho	me 5 Reside	nce 6 □Other (Sp	ecify)
	ng P	Ë	27. Manner of Death 1 Natural 5 Pending (Month, Day Yea	28b. Time of	f unk 28c. Injur Wor	y at	28d. Describe ho	w injury occurred	unk
.0	ath. or: A	atle	2 Accident investigation		M 1 🗆	Yes 2 XNo			
Division of Vital Records, P.O.	r Atte	E	3 ☐ Suicide 6 🛣 Could not be determined 28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office	unk	28f. Location (Str. City or Town	eet and Number or F	Rural Route Number. unk
	tal or rs afte al Dir	Certification:						, 5.5.0,	
	To the Hospital or Attending Physicien: The law requires that within 24 hours after death. To the Funeral Director: After this certificate hes been signed completely filled in by the funeral director, page 2 should be de	ca	29a. Certifier (Check only 2 Medical Examiner: On the basis of exam	knowledge, death	h occurred at the tir	me, date and place,	and due to the ca	use(s) and manner a	as stated.
	the Fin 24 the Fin 24 the Final	Medical	one) 21 and manner stated.						
	To the within 2 To the comple	2	29b. Signature and title of certifier		29c. Licens		29	d. Date signed (Mor	ith, Day, Year)
			▶ Carol Hallan	ind	0.0	.M.E.	A	ugust 29,	2005
			30. Name and address of person who completed cause of death			,			01.001
			CAROC HACAD MO		renn St	reet, Bal	timore,	Maryland	21201
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's S		and s				
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			For State Registrar		State	of Ma	aryland /	Depa <i>Cer</i> t	rtment d tificate	of He	ealth and N Death	Mental Hy	gien Reg. N	2005	291	17
	Physic	ian	Decedent's Nam			~						2. Date of De		ay Year	3. Time of De	
	/Medi	cal	Emma Katl		<u>_</u>		ney		45 Oit T-					2, 2005		ОРм
	Examir	ner	4a. Facility Name (Gilchrist			number)			Tow		ocation of Death		4	c. County of Dea Baltin		
	Funeral Director		5. Social Security (214-03-56	541	6. Sex 1 ☐ M 2 X		90 (In yrs. last bi	Yrs.	If Under 1 \ Months D	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di April 2	rth ay Yea 21,	1915 Mai	thplace (State or Fountry) Cyland	oreign
7	land		Usual Residence of 10a. State	10b. County			10c. City, Tov	vn or Loc	ation		·				10d. Inside City	Limits
	ith the Marylan or 28a-1 show	tor	Maryland	Balti	more		Balt	imor	e						1 ☐ Yes 2	
	or 284	Oirec	10e. Street and Nu						10f. Zip Co	ode			10g. C	Citizen of What C	ountry?	
	s 23a	Funeral Director	6451 N. C	harles				1.2.11		212				nited St		
92	ies, with yield A 12.15-0050 stand 2 should be filed within 72 hours after death with the Maryland f Health and Mendal Hyglene. If Health and Mendal Hyglene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, If a Medical Event invariate routified at	by Fun	11. Marital Status 1 ☐ Never Mari 3 🏋 Widowed		ied Armed	lForces? es 2.1X∏N	Ever in U.S. Io	11	as Deceden Yes, specify	Cuban,	panic Origin? (Sp , Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi Specify:		
3	72 hours	ted		15. Deceden	t's Education		16a	. Decede	nt's Usual C	ccupati	ion		16b.	Kind of Business		
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/	ild be ked o	To Be	John Laor								Adelaide		, maiue	in Surraine)		
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	ages 1 at of H or ot			Cremation	3 Removal fro	om State		ry, crema	atory or othe	r place)) !	Date		Location - City or		
3000	nit. Parantme antme ortant injury		4 ∐Donation 21. Signature of Fi	5 Other (S			Most Ho				em.Sep. 7				Maryland	1
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8			23 1 art1. Enter shock, or hea	the disease, or art failure. List	complications th	at caused on each line	the death. Do	not enter			such as cardiac				Approximate Interval Between	en
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3	res that the igned by be detac	by Pt	Part II. Other signi	ficant condition	ons contributing to	o death bu	t not resulting i	n the und	lerlying caus	e given	in Part I.	23e. Did t	obacco	use contribute to	the cause of deat	:h?
-C	v require been sig should b	ted t										1 🗆 '	Yes 2	2 □ No 3 □ Pr	obably 4 Unk	nown
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Z.	Physician: The this certificate	Be	25. Was case reference examiner?	/	Hospital:						26. Place of Death	h Check only o	ne)			
36	Phys this ral dii	5	1 Yes 2 2		28a. Da	☐ Inpatien ite of Injury	/ 28b.	tpatient_ Time of	3□ DOA 28c.	Other: Injury a	4 Norsing no	me 5 Resident			city) NOSPI	ke
lene	E # 9	atior	1. Natural 2 ☐ Accident	5 Pendin investig	9	lonth, Day		Injury	М	Injury a Work? 1 Ye	s 2 No			ary coourrou		
URE	al or Atts s after de il Directo	Certification:	3 🗍 Suicide 4 🗍 Homicide	6 🗌 Could r determ	ined 288. Pl	ace of Injur ilding, etc.	ry - At home, fa (Specify)	arm, stree	et, factory, of	fice		28f. Location (S City or Tox	Street a vn, Stat	nd Number or Ru e)	ıral Route Number	,
3	To the Hospital or Attandi within 24 hours after death. To the Funeral birector: A completely filled in by the fu	edical (29a. Certifier (Check only one)	1 €ertifyin 2 Medical	Examiner: On the	the best of basis of a anner stat	examination an	e, death o	occurred at the stigation, in the	he time, my opin	, date and place, and occurr	and due to the ed at the time,	cause(s date an	s) and manner as ad place, and due	stated. to the cause(s)	
	To the within To the comp	Ž	29b. Signature and	title of certifier	0	~			29c. Li	cense n	_			ate signed (Monta		_
	150		All			(A)				> (1 >05		54	ptembe	C 5001	
	20		30. Name and add	ress of person	·	_	ath (Item 23a)	(Type, Pr	into	erl	4 51	DUSSON	Va	20212	of 5 5002	
4	Sta Registr		31. Date filed (Mor	SEP 0	7 2005	. Registrar	r's Signature	A	artes							

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Baltimore,

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

KONGU111 Penn Street, Baltimore, Maryland 21201

)59	75			State of Maryl				•	•	
			1 - State Unpend Item Registrar 1. Decedent's Name (First, Middle,	Last)	per me	rtificate of	Death ^{tas}	2. Date of Death	3: Time of Dea	20
	Physici /Medi		John Sampogna	<u> </u>				Septembe		М
1	Examir	er	4a. Facility Name (If not institution, § 3264 Corporate C				r Location of Death Ott City		4c. County of Death Howard	
	Funeral		5. Social Security Number 6	. Sex 7. Age (In)	rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	9 Birthplace (State or For	reign
	Director		215-48-9698 Usual Residence of Decedent	10XM 2□F 44	Yrs.	World Days	Tiours Will.	Jan 24 1	961 DC	
	Maryland -f ehow lied at	tor	10a. State 10b. County Md Carrol	1	City, Town or Lo Sykesvi				10d. Inside City Lin 1X Yes 2 □	
	h with the	al Director	10e. Street and Number 151 Riverview Tr	rail		10f. Zip Code 21784		100	g. Citizen of What Country? USA	
980	d within 72 hours after death with the Maryland Jiene. r than "naturel", or Iteme 23a or 28e-f ehow The Medical Examinar must be nutified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 Yes 2 W No If Yes, Give A Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☒ No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Pican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Baltimore, Maryland 21215-0036	within 72 hor ene. then "natur he Medical i	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired ICSS OWNE	during most of work d)	ring	bb. Kind of Business/Industry	
ind 21	be file ital Hyg id otherwent,	Be	12 17. Father's Name (First, Middle, La Nicholas Sampos	·	Dusti	less owne		e (First, Middle, Ma		
Maryla	s 1 end 2 should be Health and Mental Item 27 Is marked o other traumatic eve	2	19a. Informant's Name/Relationship Mrs. Julie Sampos	(Type, Print)			and Number or Rui	al Route Number, (City or Town, State, Zip Code)	
nore, l	ages 1 end 2 nt of Health i: If Item 27 or other tra		20a. Method of Disposition 1 □ Burial 2 【XCremation 3	☐Removal from State	b. Place of Dispo cemetery, cren	esition (Name of matory or other place		Date 20	c. Location - City or Town, State	-
Baltin	permit. Pages 1 Department of H Important: If Ite any Injury or ot ance.		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lice	censee	22	2. Name and Addre	ss of Facility Hai		kesville, Md	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused the divided the d	leath. Do not ent	er the mode of dvir	o such as cardiac	or respiratory arres	Approximate	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	doxylamine Due to (or as a con	intoxic	cation	on combin	ed with a	1coho1 and Interval Between	1
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8760,	ate be executed hysiclen and the burial-transit	lical Examin	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a con	sequence of):					
P.O. Box 68	thet the death certificate today the ettending physic detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time 9□Unknown	etal death 3[Ectopic pregnancy Other (specify)	,		23d. Date of delivery Month Day Year	
	law requires thet the es been signed by th 2 should be detache	þ	Part II. Other significant condition	s contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.		cco use contribute to the cause of death′	
of Vital Records,	The ete h page	Completed						24a. Was an autopsy performe 1 X Yes 2 D		able of
Zi.	고 8 8 8	To Be	25. Was case referred to medical examiner? 1 □Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	ot 3F DOA Oth		h <i>Check</i> only one)	ce 6 Dother (Specify) at scer	ne.
	nding Physis ath. r: After thi e funerat		27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injur Wor	y at k?	28d. Describe how Subject i		es
Division	To the Hospitel or Attending Phywithin 24 hours atter death. To the Funerel Director: Atter this completely filled in by the funeral director.	Certification:	3 M Suicide 6 □ Could no 4 □ Homicide determina		t home, farm, str			28f. Location (Stre City or Town,	et and Number or Rural Route Number. State 3264. Corporate C City, Maryland	
May	Hospit 24 hour Funer tely fill	edical	(Check only 2 X Medical Ex	Physician: To the best of my aminer: On the basis of exam	knowledge, death	n occurred at the tir vestigation, in my o	ne, date and place,	and due to the cau		
/	vithin 2 To the	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			. Date signed (Month, Day, Year)	
)	point		I his his	, mid		C	.C.M.E.	Se	eptember 02, 2005	
0	LV		30. Name and address of person wh							
	Sta	te	21NCy CT 31. Date filed (Month, Day, Year) SEP 0	32. Registrar's Si	gnature "	I Penn St	reet, Bal	timore, I	Maryland 21201	
	Regist		SEP 0	7 2005 32. Registrar's Si	US ,	Goods				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2 0 0 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frederick Anthony Strassner Jr. 3:00 AM Dent 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Air Be l Health Mariner 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/21/1922 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2□ F 82 219-18-7748 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and tof Health and Mental Hygiene. ant: If item 27 is marked othar than "natural", or items 23a or 28a-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic avant, the Modical Equitible roughty notified at MD Harford Abingdon Completed by Funeral Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2619 Parrell Path 21009 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XNo Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Exxon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Frederick Anthony Strassner Sr. Martha Karwacki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

22. Name and Address of Facility

3 Ectopic pregnancy

5 Other (specify)

Metro Crematory

Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

neumonia

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

28a. Date of Injury (Month, Day Year)

4 Pregnant at time of death

Physician /Medical

= 5 permit. Page Department of Important: If any injury or once.

Examiner

Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was case referred to medical 27. Manner of Death

Certification; To Medical 29a. Certifier

Immediate Cause (Final disease or condition resulting in death)

Lisa Maines

20a. Method of Disposition

¹ 4 □ Donation 5 □ Other (Specify)

21. Signature Fune al Service Licensee

in the past 12 months?

1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State

the burial-transit funeral director, page 2 should

31. Date filed (Month, Day, Year) State Registrar

examiner

1 🗌 Yes

1. Natural 2 Accident

3 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending

investigation

6 Could not be determined

North Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

134652

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ■No 3 ☐ Probably 4 ☐ Unknown

Miller-Dippel Funeral Home Inc.

Baltimore, Maryland

Approximate Interval Betweer nset and Death

Bil Dir Maryland

performed 2. No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2619 Parrell Path Abin don, Maryland 21009

9/7/05

Date

6415 Belair Road Baltimore, Maryland 21206

DHMH 17 Rev 1/2001

-rederick

Hospital or Attanding

Director:

within 2 To tha

				1 = For State Registrar	State of M	laryland / [Departm <i>Certific</i>	ent of l ate of	Health and I Death	Mental Hygi Re	ene g. No.	05	29122
	- 2.	Physicia		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day	Year	3. Time of Death
		Physici /Medi		Nelson	Ja	mes	7	Thomp	oson Sr.				18:46 M
	1	Examir	ner	4a. Facility Name (If not institution,			4b. 0	•	or Location of Deatl	ו		ty of Death	
		· 数	93 -	Gilchrist Nur 5. Social Security Number		ge (In yrs. last bir	th days If Li	TOV	VSON	8. Date of Birth	Bal	timo	
		Funeral Director		219-32-3021	1 M 2 F 7. A		Yrs. Mon			(Month, Day,		Gou	place (State or Foreign ntry)
				Usual Residence of Decedent						08 23	35		MD
		rylan	_	10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
		8a-1 s	cto	MD NA		Balt	imore	9					¹₹Yes 2□No
		or 24	Director	10e. Street and Number			10f	. Zip Code		10	g. Citizen o	What Cou	ntry?
		a 23a		3638 Forest H					21207			J.S.A	
		be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural" or Items 23s or 28s-f show event, the Medical Examener must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent Amed Forces' d 1 ☐ Yes 2 🌠	?	If Yes,	ecedent of specify Cut	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ice - Amen ack, White	can Indian, etc.
	336	al', or	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		1 ☐ Ye	s X No	Specify:		Spec	ity: Bl	ack
	215-0036	2 hou	ted	15. Decedent's	Education	16a.	Decedent's I	Usual Occu	pation		6b. Kind of		
	21	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NO	T work done T use retire	during most of wor ed)	King			
	2	ed wi	ပ်	12th grade	na		Labo	orer					ompany
	gug	be fill	Be	17. Father's Name (First, Middle, L						ne (First, Middle, M	aiden Suma	me)	
	2	d Mer nark	2	John Thompson 19a. Informant's Name/Relationshi		4.01	14-17- A 11	/2:	Alice				
	Maryland	es 1 and 2 should be filed within of Health and Mental Hygiene of Hem 27 is marked other than "r other traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event, "in Mental Andre traumatic event," in evental event ev								ral Route Number,			
		f Heal		Marie Dinkins 20a. Method of Disposition	-rriena	20b. Place of cemeter				d., Bal	C I MO I Oc. Location		
	υO	Pages nent of H int: If Ite		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		,				0 /05	D = ~	11	. M -
	Baltimore,	그 든 판 글		21. Signature of Funeral Service Li		King	22. Nam	e and Addr	Park 9/ ess of Facility	0/05	Kanua	IIISC	own, Md
	ä	Depar Impo		1 2/elie	Edmon	de	Marc	ch F/	H West	, Balti	moro.	ма	21215
				23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	d the death. Do	not enter the	mode of dy	ing, such as cardiac	or respiratory arres	st,	na	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	101	Nem	12-						Onset and Death
46		/Medical		resulting in death)	Due to (or as	s a consequence	of):						rvariion
181	~4.0	Examiner		Sequentially list conditions,	b								
10		ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as	в в голянориалев	of):						
00		and and Il-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):					-	
-2005	68760,	ficate be executed physician and s the burial-transit											
7	687	ficate p physics ts the	edicai		σ.								
Ó	Box	nding use a	N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		-				23d. D	ate of deliv	erv
60	Ď.	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a	2 ☐ Fetal death at time of death	3 ∐Ectopi 5 ☐ Other	ic pregnand r (<i>specify</i>) _	;у 			onth	Day Year
	P.O.	at the by th tache	hys	9 🗆 Unknown	9□ Unknown								
Melson Shampson	S,	gned be de	by F	Part II. Other significant condition	s contributing to death t	but not resulting in	n the underlyin	ng cause gi	ven in Part I.	23e. Did toba	cco use cor	tribute to t	he cause of death?
3	ord	equir en si ould				 				1 🗌 Yes	2 □ No	3 ☐ Prot	pably 4 Onknown
3	Ö	law r las be	Completed							24a. Was an autopsy	24b	Were auto	ppsy findings available impletion of cause of
3	= =	The cate h	Con							performé	ed? X No	death?	
To	/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	11	000-012-010-71				th Check only one			
	of	Physic this c	5	1 Yes 2 No	Hospital:			IDOA		ome 5 Residen		her (Specif	n hospice
\$	UC	ding 1. After funer	ion	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da		Time of njury M	28c. Inju Wo	iryat ork?]Yes 2 ∐No	28d. Describe how	injury occu	rred	
3	isi	death death ctor: y the	ficat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 390 Place of In	jury - At home, fa				28f Location (Stre	et and Num	her or Rue	al Route Number,
200	Division of Vital Records,	after Dire	Certification:	4 Homicide determin	building, e	tc. (Specify)	mi, street, lat	atory, orrice		City or Town,	State)	uer or nare	is noute Number,
>		papita hours ineral y filled		29a. Certifier Certifying	Physician: To the best	of my knowledge	, death occur	red at the ti	me, date and place	and due to the cau	se(s) and m	anner as s	tated.
		To the Mospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use an	edical	(Check only 2 Medical E.	kaminer: On the basis of and manner st	of examination an	d/or investiga	tion, in my	opinion, death occur	rred at the time, dat	e and place	and due to	the cause(s)
		Vithi To ti	W	29b. Signature and title of certifier	0			29c. Licen:	_		d. Date sign		
			>/	After	my			DS	8303	Se	phem	Jer 6	5 2005
	1	701		30. Name and address of person w		death (Item 23a) ((Type, Print)	10/-1	at D	lecal ann	712	al	
		V		31. Date filed (Month, Day, Year)			- Cru	vus .	yr jon	ISUN MO	46	1	
		Sta Registr		SFP (7 2005	rar's Signature	· An	A . 3					

			For State Registrar	State of Ma	aryland / De	partment of ertificate of	Health and Death	Mental Hyg	iene _{9. No.} 2005	5 29123
,	Physici /Medic		1. Decedent's Name (First, Middle, Las Catherine H	t)				2. Date of Deat Month EPTEMBER	h Day Year	Time of Death
	Examir		4a. Facility Name (If not institution, give Saint Joseph h		Center	4b. City, Town,	or Location of De		4c. County of Dea Balt	imore
	Funeral Director		5. Social Security Number 6. So 108–10–0024	9X 7. Age □ M 2	94 (In yrs. last birtho	Months Dav			Year) Co	thplace (State or Foreign ountry) ew York
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. fnside City Limits
	e Man	ctor	Maryland Balt	imore	Tov	son				1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of What Co	•
	death me 23	Funeral	1213 Culvert Road	12. Was Decedent 6	Ever in U.S.	3. Was Decedent of			United Sta	
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or iteme 23a or 28a-f show imatic event, the Modical Examinat must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X X If Yes, Give Year or Dates:	ło	If Yes, specify Cu		arto Rican, etc.)	Black, Whit	white
5-0	"natur	letec	15. Decedent's Ed (Specify only highest gra-	ucation de <i>completed)</i>	16a. De	ecedent's Usual Occi ive kind of work don- e. DO NOT use retir	upation e during most of w	orking	16b. Kind of Business	/Industry
Maryland 2121	yene.	Completed	Efementary/Secondary (0-12)	College (1-4or 5 -0-	+)	o. <i>Do Noru</i> so <i>reur</i> Iomemaker	ea)		Own Home	
nd	be filed tal Hygid d other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, N	faiden Sumame)	
<u> </u>	should be nd Mental i marked o	P L	Patrick 19a. Informant's Name/Relationship (7)	una Deinti	Hann		Mary	3	Rooney	-
	2 4 4 5		Mr. Wilfred L. Tu					lston, Mai	City or Town, State, 2	21p Code) 047
Itimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of Di	sposition (Name of crematory or other pl			20c. Location - City or	
Ē	permit. Pages Depertment of I Important: if it any injury or o		4 ☐ Donation 5 ☐ Other (Specify	Dul.	anev Vall	ey Memori	al Gdns	2005	Timonium.	Maryland
Ba	Depermine timbor in any ir conce.		21. Signature of Funeral Service Licen	0	Brian T	Chishol	m Funera	1 Serives	of Dulane	y Valley, P.
	All I		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	the death. Do not	enter the mode of dy	ring, such as cardi	ac or respiratory arre	ium, Maryl	Approximate Interval Between
ď	Physician		fmmediate Cause (Finaf disease or condition resulting in death)	a. PNEUMON	NIA					Onset and Death
	/Medical Examiner		Todaling in dealiny		a consequence of): RENAL FF	ATLURE				
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	corisequence of).					
	and I-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of);					
68760	ficate be executed physician and is the burial-transit	edical E		d.	30,,30420,,30					
		Medi	IF FEMALE:							
P.O. Box	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetaf death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date of del Month	livery Day Ye <i>a</i> r
	res that the de signed by the a be detached f	by Ph	Part If. Other significant conditions co	entributing to death bu	it not resulting in th	e underlying cause g	iven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ords	w require been sig should b							1 🗆 Ye	s 2 No 3 Pr	robably 4 Unknown
Vital Records,		Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
<u> </u>	Phyeicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		C	No. or or	eath Check only one		
Division of	Attending Phyeicien: or death. ector: After this certifice by the funeral director.	-	1 Yes 2 No 27. Manner of Death	1 X Inpatie 28a. Date of Injur (Month, Day	v 28b. Time	e of 28c. Inju	4 Nursing	Home 5 Resider	nce 6 Other (Spec w injury occurred	cify)
SIO	tending eath. tor: After the funer	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1[]Yes 2 □No			
\leq	el or At s after d il Direct d in by	Certification;	4 Homicide determined	28e. Place of Inju building, etc	ry · At home, farm, . (Specity)	street, factory, office	•	28f. Location (Str. City or Town,	eet and Number or Ru State)	iral Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) Certifying Physical Exam	rsician: To the best of iner: On the basis of and manner sta	examination and/or	eath occurred at the rinvestigation, in my	time, date and place opinion, death occ	ce, and due to the calcurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	Vithii To th	Ž	29b. Signature and title of certifie	no 11.		29c. Licer	ise number		d. Date signed (Monti	
7	~	/	20 Name and Helina of	WI CHE	M · ()	D41	410	Se	flambor 0	157, 2015
1	7		30. Name and addréss of person who of JOGINDER F. MEI				VE TOWS	ON, MARY	LAND 212	04
10000	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7	32. Regulatra 2005	r's Signature	poste				
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			1 - For State Registrar	State of Marylan		irtment of H			2005	29124
			Decedent's Name (First, Middle, Last)		-			2. Date of Death		3. Time of Death
	Physici		Alice	Myra	Tremp	er		Month A11911St	Day Year 2005	6:12 A M
æ	/Medi Examir		4a. Facility Name (If not institution, give s				Location of Death	nagast	4c. County of Death	
	= Admin		5319 Sweet Air Roa	ad		Baldwin			Baltimore	County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	0.010	place (State or Foreign ntry)
	Director		214-96-5131	M 2XXF 34	Yrs.	Months Days	Hours Min.	0. Date of Birth (Month, Day, You Dot. 5,19	70 Mar	yland
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c Cin	, Town or Lo	nation				104 1-14- 0:1:
	aryia sho	Ä	,		, TOWITOI LO	Jation				10d. Inside City Limits 1 ☐ Yes 2€ No
	the N	Director	Maryland Baltin 10e. Street and Number	nore		101 To Octo]	Baldwin	0:: (100) 0	
	with a or	ត់		\ 3		10f. Zip Code	21.01		Citizen of What Cou	•
	eath	Funeral	5319 Sweet Air I	(Oad 12. Was Decedent Ever in U.	S 13 V	Vac Decedent of Hi	2101:		United St	
	ter d	'n.	1 Never Married 2 Married	Armed Forces?	3.	Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto F	Rican, etc.)	Black, White,	
336	urs at		3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1	☐ Yes XX No	Specify:		Specify: W	hit e
ō	within 72 hours after death with the Maryland ane. than "natural", or items 23e or 28e-f show he Medical Exeminer must be notified at	ted	15. Decedent's Educ	eation	16a. Deced	ent's Usual Occupa	ition	161	b. Kind of Business/In	dustry
215	hin 7	be	(Specify only highest grade	Completed) College (1-4or 5+)	life. L	kind of work done a OO NOT use retired,	during most of workir	ng		
21	filed wil Hygien ther than	Completed by		4 Years	Sy	stem Ana	alyst	Ç	uicken Lo	ans
p	al Hygi d other went, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name			
yla	Mental Mental arked o	ည	Edward M. Machov					Jacquelin	ne V. Ying	ling
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (Ty)						ity or Town, State, Zip	
	and ealth n 27		Mr. Edward Machove				Court Pho			1131
0			20a. Method of Disposition 1	emoval from State	emetery, cren	sition (Name of natory or other place	9)		c. Location - City or To	
Ë	artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify)	Sa			sus Cem.	9/3/2005	Dundalk	, Maryland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	No - 1-		Name and Addres		ome of Du	ındalk, In	G.
	00200		QUEDIUNE 1	Tussey		922 Wise	Ave. Dun	dalk, Ma:	ryland 21	.222
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each line.	n. Do not ente	er the mode of dying	g, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		[]	Due to (or as a consequ	uence of):		t	,		
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	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	240 10 (0) 43 4 00/13040	1611C6 C1).					
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60		_			•					
9289	ath certificate be tending physicle or use as the bur	dlo	- 0							
XO	nding use a	/W	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna					23d. Date of delive	arv
ă	death a atte	cla	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
0	The law requires that the death certificate be the best been signed by the attending physicis age 2 should be deteched for use as the bunge.	Physician/Medical	9 QUnknown	9□ Unknown						
0.	s that ned b	by P	Part II. Other significant conditions con	tributing to death but not resu	ılting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
rds	quires n sign uld be	p p						1 ☐ Yes	2 ☐ No 3 ☐ Prot	ably 4 Unknown
Records,	s been s shoul	Completed						24a. Was an	24b. Were auto	psy findings available
	The law cete hes page 2 :	E						autopsy	prior to co death?	mpletion of cause of
Vital		Φ	25. Was case referred to medical				26. Place of Death	Check only one	No 1 es	2 LI No
\geq	Physician: this certific al director,	OB	examiner? 1XXYes 2 ☐ No	ospital: 1 Inpatient 2 I	ER/Outpatient	3 DOA Othe	_		e 6 ther (Specif	at scene
ı of		T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury		8d. Describe how i		,
io	Attending I r death. octor: After by the funer	atlo	1 □Natural 5 □ Pending 2 □ Accident investigation	Formel 8/30/00		AM 1 Y		reflective	cerved sho	pe from +
Division	Attencer death	tt E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Rura	l Roue Number,
ā	rs efter el Dire ed in b	Certification:	T	January, Ste. (Specify	_N.	ichne		sald	way Many	and and
	To the Hospitel or Al within 24 hours effer of To the Funerel Directompletely filled in by		29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examinat	wledge, death	occurred at the time	e, date and place, a	nd due to the caus	e(s) and manner as s	tated.
	To the H within 24 To the Fi complete	ledical	Une)	and manner stated.	and/or inv			u at trie time, date	and place, and due to	o trie cause(s)
	With To 1	Σ	29b. Signature and title of certifier	1 .		29c. License	number	29d.	Date signed (Month,	Day, Year)

State Registrar

30. Name and address of person who completed cause of teach (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year)
SEP 0 7 2005

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760,

29c. License number O.C.M.E.

August 31, 2005

			Please T	ype or Print in Blac State of Maryland /			•	_	20125
			For State Registrar	State of Maryland /	Certificate of L		Reg.	L 0 0 0	29125
18	Physici	an	1. Decedent's Name (First, Middle, Last) ANDREW	1.116	. 1	2	Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or	Location of Death	est L	2005 4c. County of Dea	
*	L Admin		StellA Mari			MONIUM If Under 24 Hrs. 8		BALTI	
	Funeral Director		5. Social Security Number 6. Sex 230 -09 - 9562 Usual Residence of Decedent	M 2 F 7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yes	9. Bin	thplace (State or Foreign ountry)
	death with the Maryland ma 23a or 28a-f show Imust be notified at	ctor	10a. State 10b. County	TIMORE 10c. City, To	wn or Location PARK U	ille			10d. tnside City Limits
	a or 28	Director	10e. Street and Number	Green DR	10f. Zip Code	21234	10g.	Citizen of What Co	•
	er death w Itama 23a	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi		y Yes or No-	14. Race - Ame	erican Indian,
36	a o E	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No U.S.	1 ☐ Yes 2 ☐ No	Specify:	an, etc.)	Black, Whit	hite
21215-0036	72 hours "natural",	ted b	15. Decedent's Educ	Year or Dates: NAVY	a. Decedent's Usual Occupa	ition	16b	Kind of Business	
1218	ne. han "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Coltege (1-4or 5+)	(Give kind of work done do)		RSO,JA L	600
d 21	be filed within tal Hygiene. Id other than event, the Me	e Co	17. Father's Name (First, Middle, Last)	AIA	Supervis	18. Mother's Name (/			Corri
/lan		To Be	BARON Wilso	is contained and the contained		ALice (LUMMINE	Cham	
Maryland	s 1 and 2 should i Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty)	pe, Print) 19	b. Mailing Address (Street a				
	Health Health tem 27 other t		20a. Method of Disposition	20b. Place	5/8) ICR wee of Disposition (Name of	Dat	9 200	2123 Location - City of	
ē	Pages nent of int: If If		Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	tery, crematory or other place word CeM	1/6/	05	Boito 1	W.
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other traisons.	l	21. gnatur of Funeral Service License	tella	22. Name and Addres HARTLEY M 7527 har	s of Facility_STA	elia Fun Balte-M	enal Ho	ME CHTD.
77	**************************************		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ARTERIOSCLEROI		CULAR DISE	ASE		Onset and Death
	Examiner		O	Due to (or as a consequence	e or).				
F	sit ad	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of).		-		
	executed n and al-transit	Ехап	that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
68760,	ficate be exec physician and sthe burial-tr								
39 x	entifica ding ph	/Med	IF FEMALE:	3c. If yes, outcome of pregnancy				204 B 4 4	F
S. Box	Attending Physician: The law requires that the death certificate be executed reach. •ctor: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal deal 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of de Month	Day Year
, P.O	es that the de igned by the be detached	y Phy	Part II. Other significant conditions cor	tributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
rds	quires en sign	ed by					1 ☐ Yes	2 □ No 3 □ P	robably 4 Munknown
eco	e law requ has been je 2 shouli	Completed					24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
a B	ician: The l certificate ha rector, page						performed 1 ☐ Yes 2 💢		2 □ No
Division of Vital Records,	Physician: r this certifica ral director, i	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Othe	26. Place of Death (6 4 ☐ Nursing Home		6 X IOther (Spe	cify) HOSPICE
n o	ding Ph J. After th funeral	on: 1	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year) 28b	. Time of 28c. Injury North	at 286	d. Describe how in		2002 200
isio	l or Attendi after death. Director: A I in by the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,		/es 2 □ No 28	Location (Street	and Number or R	ural Route Number,
Div	al or A s after il Dire	Certification:	4 Homicide determined	building, etc. (Specify)	talin, stroot, tallary, amou		City or Town, St		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medicai (sician: To the best of my knowledger: On the basis of examination a and manner stated.					
	To th within To th comp	Me	29b. Signature and title of certifier)	29c. License	number	29d.	Date signed (Mont	h, Day, Year)
,	210		/ /		D	15125		9/2/	05
İ	Cal		30. Name and address of person who co			TIMONIUM,	MD 2109	3	
8,8	Sta							-	
2	Regist	-3	SEP 07	2005	13 Acres 8				
UF	IMH 17 Rev 1/2	JUI		32. Registrar's Signature	RIGINAL				

ANDREW WILSON

PATRICIA LYNN WELLS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ĺ			Amend Item 1 1 - State Unpend Item 2	& State of Marylar 23a,pt.II,27 pe	nd / Departme er me G847	ent of Health and 9-16-05 tas	Mental Hygier	2005 29126
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, La PA+RICIA 4a. Facility Name (If not institution, give	L'YNN	1	NELLS ty, Town, or Location of Dea	2. Date of Death Month I AUGUST 31	Oay Year 3. Time of Death
X	Funeral Director	CI	3114 E. NORTHERN 5. Social Security Number 6. S 214 - 82 - 7557			BALTIMORE CIT	S. 8. Date of Birth	N/A 9 Birthplace (State or Foreign
3	the Maryland 28a-f ehow notified at	rector	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	10c. Ci	ity, Town or Location 4 Himere	Zip Code	100.0	10d. Inside City Limits 1,2 Yes 2 □ No Citizen of What Country?
9	72 hours after death with the Maryland naturel; or Items 23s or 28s-1 show iteal Examir at must be notified at	y Funeral Director	6116 FAIR DC 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give	J.S. 13. Was De If Yes, s	Z 1 Z 0 6 cedent of Hispanic Origin? (: pecify Cuban, Mexican, Pue		14. Race - American Indian, Black, White, etc. Specify: 1, 1, 5
1215-0036	- 22	Completed by	3 Widowed 4 Devorced 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Year or Dates:	16a. Decedent's U (Give kind of life. DO NO	sual Occupation work done during most of wo	orking 16b.	Kind of Business/Industry
Maryland 21	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 ie marked other then other traumatic event, the Ms	To Be Co	17. Father's Name (First, Middle, Last DONALD 19a. Informant's Name/Relationship	Chris	topher .	SR- PA+R	time (First, Middle, Maid	en Sumame) Ho / + y or Town, State, Zip Code)
Baltimore, Ma	0 = 5		Jessica Wells 20a. Method of Disposition 1 Burial 2 Moremation 3	- Daughten 20b.	Place of Disposition (cometery, crematory)	CRALL HUENL	e Apt B-	2 Balfold 21206 Location - City or Town, State
Baltin	permit. Pa Depertmen important: eny injury once.		21. Signature of Funeral Service Lice 22. Signature of Funeral Service Lice 23. Part. Enter the disease, or com	Stella	22. Name HAR - 75.	271 STARFORD	KOAD D	FUNERAL HOME CH.T.) Altimore MANY MID 234 ADDONIMATE
760,	Physician /Medical Examiner with pringle-transit per pringle-trans	Ical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the co	nythmia quence of):	ood of syring, soon as out on	o or respiratory arrest,	Interval Between Onset and Death
P.O. Box 68	ne death certific the attending p	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 MUnknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3 Ectopic			23d. Date of delivery Month Day Year
ords, P.	w requires that the been signed by should be detact	ted by Ph	Part II. Other significant conditions of Cocaine Use	contributing to death but not res	sulting in the underlying	g cause given in Part I.		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 Munknown
ital Rec		Be Comple	25. Was case referred to medical			26. Place of De	24a. Was an autopsy performed? 1 N Yes 2 N ath (Check only one)	
of V	Phys this ai di	ဥ	examiner? 1 ∑ Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of	Other: 4 Nursing I 28c. Injury at Work?	Home 5 Residence	6 NOther (Specify) SCENE
Division of Vital Records,	or Atteated	Certification;	1 Natural 5 Pending investigatio 3 Suicide 4 Homicide	OB OBS State of Laine. At h	Injury M ome, farm, street, fact	1 ☐ Yes 2 ☐ No		and Number or Rural Route Number.
	Hospital	Medical C	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best of my knominer: On the basis of examina	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the complete	Mec	29b. Signature and title of certifier	and manner stated.		9c. License number O C M E	29d. E	PTEMBER 2, 2005
il	LY.		30. Name and address of person who	completed cause of death (Iter		PENN STREET	, BALTIMORE	, MARYLAND, 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		M 2		-

DHMH 17 Rev 1/2001

Kevin Wengert 05-06028 RPD

Physici		1. Decedent's Name (First, Middle	(ast)			rtificate			1	2. Date of De	Reg. No. 2	JUt	3 Firms of head
THYSICI	an	KEVIN MICHAEL								Month	nber 3,	Year 200	5 2254 P
/Medic		4a. Fecility Name (If not institution		ber)		4b. City, To	own, or Lo	ocation of	f Death	pepter	4c. Count		
Examin	er	University Hos				Balti						n/a	
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under 1 Months		f Under 2	24 Hrs. Min.	8. Date of Bird (Month, Da 10-2-19	h v. Yeer)	9. Birt	thplace (State or For
Director		216-27-7519	1 /X M 2□ F	17	Yrs.	Months	54,5	110010		10-2-19	987	Mar	y1änd
*		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Li
of a second	5	Maryland Anne	Arundol	G1	len Bur	nie							1 □ Yes 2/2
288-	rect	10e. Street and Number	Arunder	61	ten but	10f. Zip C	Code				10g. Citizen of	What Co	ountry?
38 o	<u>=</u>	1057 7th Stree	et			210	060				United	Sta	tes
natural', or Items 23a or 28a-f ahow dical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Deced	ces?	J.S. 13.	Was Decede	ent of Hisp	anic Orig	gin? (Spe Puerto	cify Yes or No Rican, etc.)		ace - Ame	erican Indian,
1 E	y Fu	1 Never Married 2 Marr		2X No		1□Yes 2		Specify:			Spec	· .	ite
lural E Ex	Completed by	3 Widowed 4 Divorced		tes:	16a Dace	dent's Usual	Occupation	OR.			16b. Kind of I	WII	
a Special	olete	(Specify only highes	st grade completed)	45-1	(Give	kind of work DO NOT use	k done dur. e retired)	ring most	of works	ng	100.11/10 011	Du3111633	iniousity
r tha	E	Elementary/Secondary (0-12) 12 years	College (1-		Appr	rentice	e				Sprink	1er	Company
al Hygi I othe vent,	3e C	17. Father's Name (First, Middle,								-	Maiden Suma	ime)	
Ment arked	To Be	David J. Wenger				_				. Thor			
Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f ahow Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinat must be notified at once.		19a. Informant's Name/Relations David J. Wenger)	19b. Maili 1057	7+h	Street and	d Numbe	r or Rura	<i>l Route Numbe</i> Surni⊖	or, City or Town Maryla	n, State, . nd	Zip Code) 21060
16allth m 27 her t										ate	20c. Location		
or it		20a. Method of Disposition 1/X Burial 2 Cremation	3 Removal from S		Place of Dispe cemetery, cre Ly Cros				9-8 - 2		Brookly	-	
rtant		4 □ Donation 5 □ Other (S		noı									
Depa Impo eny		21. Signatura	J. Wayne (eterli	ina 1	icCull'y	y-Pol	lynia Ave	ik Fi	neral l	Home, P e, Mary	1And	21230
	-	23a. Part1. Enter the disease, or shock or head failure. List											Approximate
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OPHELIA WILLIAMS 05-05824 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Registramend ITEM #16b PER FH C847 9/07/05 JH 2. Date of Death Month 3. Time of Death Day Year Physician 29, AUGUST 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE E.25th Street 7. Age (In vrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 F 0-232 Director filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f ehow or other traumatic event, the Mudical Examiner must be notified at 1 XYes 2 ☐ No Funeral Director Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes 22 No 'es, Give ar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: 3 Widowed 4 □ Divorced þ "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working the DO NOT use retired) 15. Decedent's Education fy onfy highest grade completed) 16b. Kind of Business/Industry PRIVATE Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent: If Item 27 is marked other then ' dry (0-12) College (1-4or 5+) Middle, Last) Mailing Address (Street and Number or Rural Route Number, City or permit. Pages 1 and 2 is Department of Health ar Important: if item 27 is eny injury or other trausonce. od of Disposition 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last this certificate hes been signed by the ettending physicien and rail director, page 2 should be detached for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other Certification: To 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ②Other (Specify) SCENE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

10

DHMH 17 Rev 1/2001

State Registrar

32 Registrar's Signature 31. Date filed (Month Day

30. Name and address of person

of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201

O.C.M.E.

AUGUST 30,2005

Maria Salar

State of Maryland / Department of Health and Mental Hygiene, For Stete Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** EPTEMBER 03. 2005 /Medical City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner (JLEN BURNIE BALTIMORE WASHINGTON MEDICAL (Birthplace (State or Foreign Country) **Funeral** 1□M 2∰F Days Months Hours Min. Yrs 91 Director 215-01-9359 21 JAN. 1914 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23s or 28s-f ehow other traumatic event, the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL **FERNDALE** 1 Yes 2000 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 WELLHAM AVE. UNITED STATES 21061 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inportant: if item 27 is marked other then "naturel", or its any injury or other traumatic event, the Madical Event has ones. 1 Never Married 2 Married ☐Yes 2 XNo Yes, Give 1 ☐ Yes 2XXXVo þ Specify: WHITE Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 THOMAS ANDREWS REBECCA BAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD W. WARREN / HUSBAND 720 WELLHAM AVE. FERNDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) SEPT. 8. 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEM. PK. 2005 GLEN BURNIE, MD 21. Signature # Funeral Service Licensee 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME P.A. X 421 CRAIN HWY. S.E. GLEN PURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only nor cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) SEP515 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) P.0. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ icete has been siç r, page 2 should b 3 Probably 4 Hunknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? certificete has autopsy performed 1 Yes 2 110 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural To the hosp..... within 24 hours after death.

To the Funeral Director: Alt 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) WASHINGTON MEDICAL CENTR BALTIMOR T5:00 BERHAME 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 SEP Registrar

WARREN GEORGIA M

			1 - State State Registrar	e of Maryland / De <i>C</i>	partment of H ertificate of L		Hygiene 0	05 29130
Ì	Physici /Medic		1. Decedent's Name (First, Middle, Last) She(UIA TEA	v Ware	N	2. Date Mon		Year 3. Time of Death
	Examin		4a. Facility Name (If not institution, give street an	d number) CenAh	4b. City, Town, or Lest M	Location of Death	4c County	of Death
	Funeral Director		5. Social Security Number 217-34-3736 6. Sex 1 □ M 2 1 □ M 2 1	7. Age (In yrs. last birthda	Months Days	Hours Min. 8. Date (Mon	of Birth th, Day, Year) 16,1936	9. Birthplace (State or Foreign Country) West Virginia
	saryland show	j.	Usual Residence of Decedent 10a. State 10b. County Marral and Baltimana	10c. City, Town or				10d. Inside City Limits
	ath with the Marylan s 23a or 28a-f show	Director	Maryland Baltimore 10e. Street and Number	Gwyi	nn Oak 10f. Zip Code		10g. Citizen of	
	s 23a c		6107 Sunny Lane	Barrier Carrier La		1207		.S.A.
036	urs after de al', or item Exter ill ar	by Funeral	1 ☐ Never Married 2X Married 1 ☐ If Ye	Decedent Ever in U.S. od Forces? yes 2 ⊠ No s, Give or Dates:	3. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, el Specify:		ce - American Indian, ck, White, etc. fy: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, it e Mudical Executions	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	16a. De (G) (G) (Iffi	ecedent's Usual Occupa ive kind of work done d e. DO NOT use retired,	ution luring most of working		Business/Industry
			11. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name (First, A	Own I	
ylan	o d la	To Be	Luther Cassell			Bertie McCa	ıghlin	
Maryland	12 shu h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Prin Bill E. Warren (Husba			and Number or Rural Route		
	of Heal item 2 other		20a. Method of Disposition	20b. Place of Di	Sunny Lan sposition (Name of crematory or other place	e Gwynn Oak,		- City or Town, State
altimore,	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal `4 ☐ Donation 5 ☐ Other (Specify)	nom state	Memorial :	!	Sykesvi	ille, Maryland
Ra	permit Depar Impor any in		21. Signature of Funeral Service Licensee	localis	22. Name and Addres litzke Fune 1030 Edmond	s of Facility ral Home of (son Avenue Ca	Catonsville atonsville	e, Inc. , MD 21228
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	/Medical		disease or condition resulting in death)	ie to (or as a consequence of):	7 Emile	UK		
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Y		Completed					autopsy performed?/	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
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2	ital or Attendii rs after death. al Director: A led in by the fu	Certification:	4 Homicide determined	Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office		or Town, State)	ber or Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical Examiner: On one) and	o the best of my knowledge, d the basis of examination and/o manner stated.	r investigation, in my or	pinion, death occurred at the	time, date and place,	and due to the cause(s)
	with To Corr	2	29b. Signature and title of certifier	y sician (Alterd	DO (063031	29d. Date signe	QUUT
	1,		30. Name and a ress of person who completed	1555 S. Cart	e St/W	stminste,	m 211	6 7
	Sta Registi	ate rar	SEP 0 7 2005	32. Registrar's Signature		/		_

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State of Maryland / Department of Health and Mental Hygiene 2005

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			1 - State Registrar	(Certificate of Death	Reg. No.	000 29101
	Dhuaisi		Decedent's Name (First, Middle, Last)			2. Date of Death Month Day	3. Time of Death
	Physici /Medio			Villiams		August 30, 2	
	Examin	er	4a. Facility Name (If not institution, give street and 751 Route 32	number)	4b. City, Town, or Location of Death Sykesville		oward
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F	7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Aug 27, 19	9. Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Ba-1 sho	Director	MD Carroll		Taneytown	1.00	1 ☐ Yes 2 ☒ No
	ath with the 23s or 2	rai Dire	10e. Street and Number 4049 North Stone Road		10f. Zip Code 21787		n of What Country? USA
920	s 1 and 2 should be illed within 72 hours after deeth with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show other traumatic event, the Medical Expirative must be indiffied at	by Funeral	1 X Never Married 2 Marned 1 Yes,	ecedent Ever in U.S. Forces? s 2 No Give X r Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify:		. Race - American Indian, Black, White, etc. pecify: White
21215-0036	hin 72 ho a. an "natu	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	ed) (Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	of Business/Industry
21	filed wit Hygiene other the	Con	12		Welder		elding
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Ms	To Be	17. Father's Name (First, Middle, Last) Dennis Williams			e (First, Middle, Maiden Su rah Watson	imame)
lary	2 sholl and his mails ma	0 1	19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Number or Run	_	
	Health Health tem 27		Mrs. Deborah Watson (Mo		4 Poole Road C-5 Wes		ZIID/ tion - City or Town, State
Baltimore,	Page nent o ant: If ury or		1X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	cemetery	Branch Cemetery 9/3	/2005 West	minster, MD
Ball	Depertrimporte		21. Signature of Funeral Service Licensee	44	HAIGHT FUNERAL HOM Sykesville, MD 217	E & CHAPEL, 1 84 (410)-795-	PA (Box 195) -1400
60,	Caracteristicate be executed my physician and physician and physician and as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of	iurice n:		Interval Between Onset and Death
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	To the Hospital or Attending Physician: The I within 24 hours elter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation: To	27. Manner of Death 1 Natural 5 Pending	Inpatient 2 EP/Out ate of Injury fonth, Day Year) 28b. Ti	patient 30 DOA 40 Not Sing Ho	ome 5 Residence 6 g 28d. Describe how injury of Suffect cutt	occurred of the second
Division	s efter de el Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus 1990 Service 29e. Plus	ace of Injury - At home, far uilding, etc. (Specify)	1		Number or Rural Route Number, 751 Aunt 32
	Hospi 4 hour Funer ely filk	ical	(Check only 21X Medical Examiner: On th	e basis of examination and	death occurred at the time, date and place, for investigation, in my opinion, death occur		nd manner as stated.
	thin 2 the 1 mplet	Medical	one) and n 29b. Signature and title of certifier	nanner stated.	29c. License number		signed (Month, Day, Year)
	F \$ F 8		ITP 111/16	_d	O.C.M.E.		31, 2005
-	1		30. Name and address of person who completed of THE DOLLE MIKING		Type, Print) Penn Street, Baltín	ore Marvland	21201
	Sta	ate		2. Registrar's Signature	Jan Serece, Barelli	ore francy rand	M T M ✓ T
	Regist	rar	SEP 0 7 2005	10 . 30	Maria Maria		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O O F

	1 - State Registrar Amend Tter 1. Decedent's Name (First, Middle,	n #2 Per Phy G847 9	Certificate of Death		. No. 8-25-2005	3. Time of Death
Physician	Claudia	Mae	Young	August	Pay 2 2 2005	30 40 11
/Medical Examiner	4a. Facility Name (If not institution,		4b. City, Town, or Location of Death		4c. County of Death	
Examine	2311 Calverto	n Heights Ave	Baltimore			
uneral		5. Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day, Y	(ear) 9. Birthpl	ace (State or Foreign try)
rector	219-14-0132	1□M 2XF 99 Y	S.	03 25	06	VA
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10	0d. Inside City Limits
Item 27 is marked other than "natural, or itame 23s or 28s - ahow other traumatic event, the Modical Examinar must be natified at. To Be Completed by Funeral Director						1 XYes 2 □ No
ect	MD NA 10e. Street and Number	Darca	10f. Zip Code	100	. Citizen of What Coun	try?
a lo		on Heights Ave	21216		U.S.A.	
iner must be natified Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
曹교	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 No	1 ☐ Yes 2 ☒ No Specify:	o Hican, etc.)	Black, White,	
Completed by	¾ ()Widowed 4 □ Divorced	ff Yes, Give Year or Dates:	TI Tes ZA NO Specily.		Specify: B1	ack
etec	15. Decedent's (Specify only highest	s Education 16a. D	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired)	king 16	Sb. Kind of Business/Inc	dustry
id	Elementary/Secondary (0-12)	Coffege (1-4or 5+)	Homemaker		House	
S	6th grade 17. Father's Name (First, Middle, L	na		ne (First, Middle, Ma		
Be				Gillia		
To	John Robert 19a, Informant's Name/Relationsh		Mailing Address (Street and Number or Ru			Code)
traumatic av	Raymond Claud		11 Calverton Hei	iahts Av	e, Balto,	Md 21216
other	20a, Method of Disposition	20b. Place of I	Disposition (Name of crematory or other place)		c. Location - City or To	
y or	Burial 2 Cremation 4 Donation 5 Other (Sp	3 Removal from State	don Park 9/1/	/05 B	altimore,	Md
any injury or other tra	21. Signatur 1 Funeral Service L		22. Name and Address of Facility March F/H West			
any l	Numara	O. Munkt	4300 Wabash Ave	Baltim	ore, Md	21215
	23a. Pa /1. Enter the disease, or one or heart failure. List	complications that caused the death. Do not only one cause on each line.				Approximate Interval Between
g physicien end strength as the burial-transit active burial-transit edical Examiner	Imr ediate Cause (Final dispase or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or a consequence of Due to (or as a consequence of Due to (or as a consequence of	Harythma Hara			
0 0 0	IS SELVING	1			1 200	
page 2 should be detached for use completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 5€No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	Day Year
be detac	Part ff. Other significant condition	ns contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	3.
should b				1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
mpie		No. of the last of		24a. Was an autopsy	prior to coi	psy findings available mpletion of cause of
E CO				perform 1 Tes 21	death? ☐ No 1 ☐ Yes	2 🗆 No
Be (25. Was case referred to medical examiner?			ath (Check only one		
	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Out			ce 6 Other (Specific	y)
tunera tion:	27. Manner of Death 1 Natural 5 Pending		jury Work?	28d. Describe how	Injury occurred	
cat	2 Accident investig	ot be 280 Place of Injury. At home tas		28f. Location (Stre	eet and Number or Rura	I Boute Number
ed in by the funera	4 Homicide determi	building, etc. (Specify)	in, street, factory, office	City or Town,		
Medical Certificat	29a. Certifier 1 Certifyin (Check only one) Medical	g Physician: To the best of my knowledge, Eximinar: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occur	e, and due to the cau arred at the time, da	use(s) and manner as s ee and place, and due to	tated. o the cause(s)
completely filled in by the Medical Certifical	29b. Signa ure and title of certifier		29c. License number	i i	d. Date signed (Month,	
0	A ATTOON	11/2/1/1	1)5562+		9-10-10	1~
2						
1	30 Name and address of parent	who completed cause of death (Item 23a)	Type Print)	1	, 0 0,00	3
	30 Name and address of person	who completed cause of death (Item 23a) (Type Print) North Alchue Bo	Himae	9-6-200 , MD 212	17

			1 - For Amend Item 19	State of A	laryland G847	g_Depo Cer	artmer Tas	t of H	ealth a Death	and M	ental Hyg	gienez Reg. No.	005	29133
	Physici		1. Decedent's Name (First, Middle, Last Dolores A. Yeagy							SE	2. Date of Dea Month	Day	Year 2005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give Saint Joseph M			r	4b. City	Town, or	Location o			1	ounty of Deat	
	Funeral Director		5. Social Security Number 212-26-2407 6. Se	X 7. / □M 25kF	Age (In yrs. la 76	st birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 12/1/1	h y. Year) 928	Co	hplace (State or Foreign untry) aryland
	ryland how		Usual Residence of Decedent 10a. State 10b. County			Town or Lo								10d. Inside City Limits
	the Ma	recto	MD Baltimo	ore		erry		p Code				10g. Citize	n of What Co	1 ☐ Yes 2 ☑ No untry?
	h with	Ö	4300 Cardwell Aver	nue				21	236			U.	S.A.	
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show eny figury or other traumatic event, the Medical Exercitral must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Tyes 25 If Yes, Give Year or Dates	s? No		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	city Yes or No- Rican, etc.)		Race - Ame Black, White pecify: Wh	e, etc.
21215-0036	ithin 72 t e. nan "natu Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		r 5+)	`life. l	kind of wo DO NOT u	ork done a ise retired,	luring most)	of working	ng .		f of Business/	•
121	lled w tygier ther ti		12 17. Father's Name (First, Middle, Last)			Cust	omer	Serv		r'e Name	(First, Middle,			Oil Co.
Maryland	ould be fi Mental H Marked ot Marked ot	To Be	Steven Kaminski						Mar	cie K	ajowsk	Ĺ		
, Mar	and 2 sh salth and n 27 is m er traum		19a. Informant's Name/Relationship (7) Raymond Yeagy/So		A 2.22	2810	And	erson	Road	r or Aurai 1 Whi	te Mar	Th, M	rown, State, 2 arylan	d 21161
Baltimore,	Pages 1 ent of He nt: If Iten ry or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 0 4 □ Donation 5 □ Other (Specify,		e _ cer	ce of Disponetery, crem kwood	natory or	me of other place	9)	9/6/	05		ition-City or	Town, State Maryland
Balti	Departm Departm Imports eny Inju		21. Signature of une a Service Licens		*				s of Facility	1111		ppel :	Funera	1 Home Inc. d 21206
	Priysician		23a. Part I (Enter the disease, or comp shock, or neart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caus ne cause on each a. SEPSIS	line.								dryran	Approximate Interval Between Onset and Death
	/Medical Examiner	Examiner	Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SEVERE	s a conseque	PHER	AL V	ASCI	JLAR	DIS	EASE			
8760,	cate be executed by sician and the burial-transit	dicai Exe	resulting in death) Last	Due to (or a	as a conseque	ence of):								
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		2 Fetal of at time of dea	leath 3]Ectopic p] Other (s					230	d. Date of deli Month	very Day Year
rds, P.	quires that n signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death	but not result	ting in the u	nderlying	cause give	en in Part I.			bacco use		the cause of death?
		Completed			-						24a. Was a autop perfor	med?	24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
Vital	Physician: this certificant rat director, i	Be	25. Was case referred to medical examiner?	Hospital:				Othe	25		(Check only or			
of	ding Phys .n. After this funeral di	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, L		R/Outpatien 28b. Time of Injury		28c. Injury Work	4	2	8d. Describe h			city)
Division	or Attending after death. Director: Aftel in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At hon etc. (Specify)	ne, farm, str					8f. Location (S City or Tow	Street and I m, State)	Number or Ru	ral Route Number,
_	Hospital 24 hours a Funeral I	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exam	sician: To the beiner: On the basis and manner	of examination	ledge, death on and/or in	n occurred vestigation	at the time n, in my op	ie, date and pinion, deal	d place, a	nd due to the o	cause(s) ar date and pl	nd manner as lace, and due	stated. to the cause(s)
	within 2 To the complet	Med	29b. Signature and title of certifier				29	c. License	number			29d. Date s	signed (Mopti	n, Day, Year)
	1		> 221-g- ()	m-eals	3) 41	410		S	eflamb	ser this	2005
- /)		30. Name and address of person who c	ompleted cause o	f death (Item :				anger men a	en jen v	1, 3, 34, 344, 4.4	44. 1. <i>y</i> ===	ent a .ee en .	
	Sta Regist		31. Date filed (Month, Day, Year) 20	105 32 Aegis	7621 strar's Signat		arti.	IVE	LUWS	NUC	MARYL	-IND 3	21204	

		-	For State Registrar	State of Maryland / I	Department of Health and M Certificate of Death	lental Hyglen Reg. N	2000 79134
	Diam'r:		Decedent's Name (First, Middle, Last)	Λ II	COMMODIO OF DOG!!	2. Date of Death	3. Time of Death
No.	Physicia /Medic	al	4a. Facility Name (If not institution, give s	Hllen	4b, City, Town, or Location of Death	August 21	2005 19:31 M
1	Examin	er	Peninsula legion	10116	ter Salisbury		Wicomico
	Funeral Director		5. Social Security Number 6. Sep. 2 17 - 44-0904		rthday) If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)
	yland how		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	he Mar 18a-f s	Director	Md. Wicom	ico Sali	Shury	100.0	1 No 2 No litizen of What Country?
	3a or 3		10e. Street and Number	- Court	101. \$ Code 2/80/	log. c	U.S.A.
	tems 2	Funeral	71. Maritar Otatoo	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	hours after death with the Maryland turel', or Items 23a or 28a-f show al Examinat must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 □ No IfYes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
15-0	72 na #	leted	15. Decedent's Edu (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	ing 16b.	Kind of Business/Industry
21215-0036	r th	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	oduction work	er A	Hen Foods
Maryland	0 - 0 9	o Be	17. Father's Name (First, Middle, Last)	G .)	18. Mother's Nam	e (First, Middle, Maide	n Sumame)
aryl	2 should be and Menta is marked eumatic ev	ř	19a. Informan's Name/Relationship (Ty	pe, Print) 19i	b. Mailing Address (Street and Number or Rur	al Route Number, Cit	or Town, State, Zip Code)
	1 and 2 Health em 27 ther tr		Karen White	COUSIN 61		Date 20c.	cation - City or Town, State
altimore,	00===		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State	ity Constany 8-2	1-05 Ve	who md
Balti	permit. Pag Department Important: eny injury c		21. Signature of Funeral Service Licens	990	12. Name and Address of Facility B	120 S/	with Fifti
			23a. Pari 1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused the death. Do	P. O. Bex 31 Pc not enter the mode of dying, such as cardiac		Approximate Interval Between
	Physician	8. A	Immediate Cause (Final disease or condition resulting in death)	A	8CVO		Onset and Death
	/Medical Examiner			Due to (or as a consequence	of):		
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cleans of Italia)	Due to (or as a consequence	of):		
ó	execut an and rial-tran	Examine	that initiated events resulting in death) Last	Due to (or as a consequence	of):		
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d			
Box 6	leath certiff attending i for use as		23b. was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	n 3 □Ectopic pregnancy		23d. Date ol delivery Month Day Year
P.O. B	the dea / the att	Physiclan/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		World Day real
	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting	in the underlying cause given in Part I.		use contribute to the cause of death?
ord	w requir been si should I					1 ☐ Yes 24a. Was an	
of Vital Records,	The lav	Completed				autopsy performed? 1 ☐ Yes 2 ☐	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	h (Check only one)	- Ton (a //)
		n: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b.	utpatient 3 DOA Outer 4 Nursing Ho Time of linjury 28c. Injury at Work?	ome 5 Residence 28d. Describe how in	
Division	Attending or death. ector: Afte	icatlo	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, f	M 1 ☐ Yes 2 ☐ No	28f. Location (Street)	and Number or Rural Route Number,
Di≤	tel or Attenders after death	Certification:	4 Homicide determined	building, etc. (Specify)	ann, strong, ractory, omoo	City or Town, Sta	ite)
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical (ner: On the basis of examination a	ge, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	red at the time date a	nd place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
, 1			30. Name and address of person who co	empleted cause of death (Item 23a)	29c. License number H50497 (Type, Print) (COI) ST. SAUISU	0	123/00
H	,34		Chris SNYGW	100 E. CAN	(KOI) ST. SAUSO	ung mo	
	Sta Registi		31. Date liled (Month, Day, Year) AUG 2 4 20	05 Seem &	Sparke		

			For State of M 1 - State Registrar	laryland / Depa <i>Cel</i>	artment of F <i>rtificate of I</i>	lealth and N <i>Death</i>		giene 05	29135	
			Decedent's Name (First, Middle, Last)		10		2. Date of Dea Month	th Day Year_	3. Time of Death	
	Physicia /Medic		Daphne Craig		Adk		8	18 2005	1829 M	
	Examin	er	4a. Facility Name (If not institution, give street and number	1.1%		r Location of Death		4c. County of Death		
	Funeral		TENINSULD REGIONAL MEDICAL 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Upper 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign	
	Funeral Director		228-28-4309 1□M 2점F	78 Yrs.	Months Days	Hours Min.	(Month, Day March 1	19,1927 Virginia		
	Di 🖈		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Aaryla shor	5							1 □ Yes 2 🌣 No	
	28a-1	rect	MD Wicomico 10e. Street and Number	Salisbu	10f. Zip Code			10g. Citizen of What Co	untry?	
	h with	Funeral Director	1501 Handys Meadow		218	01		USA		
	ems 2	ner	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- o Rican, etc.)			
36	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Examinar must be multilised and once.	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	1□Yes 2⊠No	Specify:			ite	
21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	kina	16b. Kind of Business/I	ndustry	
2	nithin ne. hen "	mple	Elementary/Secondary (0-12) College (1-4o	r 5+) \ \tag{\text{life.}}	DO NOT use retired	d)		0 II -		
2	illed w Hygie ther ti nt, in	CO	12 4 17. Father's Name (First, Middle, Last)	Home	emaker	18. Mother's Nam	ne (First, Middle,	Own Home Maiden Surname)		
au	ld be lental l	To Be	William Reginald	Craig	or .	Lucy		Thoma	S	
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)				ral Route Numbe	r, City or Town, State, Z		
Σ	and 2 salth a n 27 l		Louis A. Adkins- husband		Handys M			MD 21801		
altimore,	ges 1 t of He If Iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	l l	Date	20c. Location - City or 1	Fown, State	
Iţi.	rtmen rtant: njury		`4 □ Donation 5 □ Other (Specify) 21. Sonature o Funeral Service Licensee		11 Mem GA 2. Name and Addre		/2005	Hebron, Ma	aryland	
Ba	Depa Impo any i		21. Shalling of Whelail Service Elections	0	705 E Mai			uneral Home ury, MD 218	04	
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each		ter the mode of dyir	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	SCVD					Oriset and Death	
	/Medical Examiner		Due to (or a	is a consequence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Unequently in a light of the cause of white)	is a consequence of):						
	cuted nd transit	Examiner	that initiated events c.							
60,	ficate be executed physician and is the burial-transit	i Ex	resulting in death) Last Due to (or a	is a consequence of):						
68760,	icate b physics the t	edicai	d							
Box (IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom 1 □ live hirth		⊒Ectopic pregnancy	v.		23d. Date of deli		
P.O. B	The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	Physician/M		at time of death 5[Other (specify)			Month	Day Year	
	that the poly detact	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the u	undertying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
rds	w requires been sign should be	ed b	Diabetes Melliss				1 🗆 Y	es 2□No 3-☐Pro	obably 4 Unknown	
eco	e law re has bee	Completed	Atonic Colon				24a. Was a	sy prior to d	topsy findings available ompletion of cause of	
œ =		Соп					perfor	med? death?	2 No	
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?		Oth		ath (Check only o			
of	S 0	T.	1 ☐ Yes 2 ☑ No ☐ 1 ☐ Inpa 27. Manor of Death		of 28c, Injur	v at		ence 6 Other (Spec	ify)	
on	Attending Physician: r death. ector: After this certificaby the funeral director,	ation	1 Natural 5 Pending (Month, L 2 Accident investigation	Day Year) Injury	Woi	rk? Yes 2 □ No				
Division of Vital Records,		ertification;	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	itreet and Number or Ru n, State)	ral Route Number,	
	e Hospitel or 24 hours afte Eunerel Dir etely filled in	O	29a. Certifier 1 Certifying Physician: To the be	st of my knowledge, deal	th occurred at the til	me, date and place	, and due to the d	cause(s) and manner as	stated.	
	he Hos in 24 h he Fur pletely	ledical	(Check only 2 Medical Examiner: On the basis one) and manner	of examination and/or in			rred at the time, o	date and place, and due	to the cause(s)	
	To the I within 2. To the I	Σ	29b. Signature and the of certifier		29c. Licens	se number		29d. Date signed (Month	4	
,	< n		My mb	f de able (Baser 02a) /T	Drint)	110+		011	7/05	
\	DATE		30. Name and address of person who completed cause of Alon Davis MD 19	death (Item 23a) (Type)		ship	mo	21804		
	Sta Regist		31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	boats ,	1				
			The state of the s	was so by	Bridge Comments					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29136 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 August Edna M. Braun 21 9:50 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Beaverbrook Assisted Living Columbia Howard If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛣 F 95 Director 215 22 5951 Aug 20, 1910 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9821 Michaels Way 21042 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Specify Completed by 3 ☑ Widowed 4 ☐ Divorced White "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Kroll Mamie Wills 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9821 Michaels Way Ellicott City, MD 21042 Mary R. Roos/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State permit. Pegi Department Important: If eny injury or once. Crest Lawn Mem. Gard. 8-24-2005 | Marriottsville, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Myoundial 405/3 resulting in death) /Medical Due to (r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury Due to (or as a consequence of) and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown þ deta signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 1 Tyes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 \square Nursing Home 5 \square Residence 6 Σ Other (Specify) assisted 1 $\sqrt{9}$ 1 ☐ Yes 2 🛣 No 10 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No М 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 22, 2005 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name Glen Burnie 21060 nd ROCSTICR ethe: CAT 115

State Registrar

Date filed (Month, Day, Year) AUG 23 2005

32. Fegistrar's Signature

1 () (4-1)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month August 19,2005 7:00am Mary S. Beatty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 8101 Connecticut Ave #306 Chevy Chase | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 31,1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 21 F Director 79 Yrs. Washington DC 578-26-4589 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic event, If a Mudical Examinar must be notified at Chevy Chase MD Montgomery 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 United States permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene
Important: If Itam 27 is marked other than "natural", or itams 23a
any injury or other traumatic event, Ita Nedical Experies 8101 Connecticut Ave #306 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Archie K. Shipe Dorothy Gascon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John J. Beatty III / Husband 8101 Connecticut Ave, #306 Chevy Chase, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State place) injury or o 1 Burial 2 □ Cremation 3 □ Removal from State St. Gabriel's Cemetery 8-24,2005 Potomac, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Joseph acid awler's Sons, INC Was 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 3 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes **X**□ No 1 🗌 Yes 2 🗌 No Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DQA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

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completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D23127 August 19,2005 20 eur 07-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . 5530 Wisconsin Ave, Chevy Chase, MD 20815 Kevin G. Nealon M.D. 31. Date filed (Month, Day, Year)

AUG 2 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Helen Burns August 19. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LaVale 541 A National Highway Allegany If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 🗓 F Director 213-82-9997 91 Yrs. 01/13/1914 Maryland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Itams 23a 541 A National Highway 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "netural", or item any injury or other traumatic event, It's Modical Examination. Black. White, etc. 1 ☐ Yes 2 Ĭ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ۵ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 Disabled None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William ပ္ Hampton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ginny Georg / friend P.O. Box 60, Cumberland, Maryland 21501-0060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Zion Memorial Park 08/22/2005 Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pheumonia as disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner phagi Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed ttekri hil atetal that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. | 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by ncapcituted sttakes trom 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s performed? certificate 1 Yes 2 LINO To the Hospital or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death Certification: 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09231 +. ween August 19, 2005 Nemal 30. Name and address of person who completed carist of death (Item 23a) (Type, Print) MAS

State Registrar

31. Date filed (Month.

Donald F. Manger, M.D.,

2005

11600 Bedford Road, N.E.,

32. Restrar's Signature

Cumberland, MD 21502

		1	For State Registrar	State of Man		rtment of F			ene g. No. 2005	29139
/N	ysicia ledic	n al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name (If not institution, give s	J. BU	CHHE		C r Location of Death	2. Date of Death	23, 2005 4c. County of Death	3. Time of Death 8:00 P M
Fune			TYDINGS PARK MARI 5. Social Security Number 219 - 92 - 5978	NA	n yrs. last birthday) Yrs.		DE GRACE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	HARFORD Year) 9 Birth Cou	CO place (State or Foreign ontry) MANTEL, MX =
he Maryland	ouried at	Director	Usual Residence of Decedent 10a. State 10b. County M.D., CEC/C		Oc. City, Town or Low	NUE		•		10d. Inside City Limits 1 ☐ Yes 2 No
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Physic /Medi Examir	cal		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	wning	ir the mode of dyin	ig, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
68760, flicate be executed physicien and			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to or as a co						
I Records, P.O. Box 687 The law requires that the death certificate site has been signed by the ettending physical for control of the standard for the standard	ched for use as the	¥ F	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive	ery Day Year
ords, P. requires that ween signed by	nouid be deta	<u>`</u>	Part II. Dther significant conditions con	tributing to death but no	ot resulting in the un	derlying cause giv	en in Part I.		cco use contribute to the 2 No 3 □ Prot	ne cause of death? pably 4 ∐Unknown
a a sc	V	Be Completed	25. Was case referred to medical examiner?				26. Place of Death		prior to co death?	psy findings available mpletion of cause of
Division of Vital Records, To the Hospitel or Attending Physicien: The law requires to within 24 hours after death. To the Funcial Director After this certificate has been signed. To the funcial Director After this certificate has been signed.	in by the luneral dire	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye Found 3/23/05 28e. Place of Injury building, etc. (S	At home, farm, stre	Au 28c. Injun Word 1	y at 2 Yes 2 No	8d. Describe how	ce 6 POther (Specific injury occurred 500 ft 100 ft	fect
Divisite Notation Attention 24 hours after deal to the Funderal Director:	pereny illied		29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of mer: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tin estigation, in my o	ne, date and place, a	nd due to the cau	ISe(s) and manner-as s	tated.
) V			29b. Signature and title of certifier Partial Justines 30. Name and address of person who come	U, MU)	(Itam 23a) (Type F	29c. Licenso			Date signed (Month, UGUST 24, 2	•
1,9	Stat	3	Particle E. Southa 31. Date filed (Month, Day, Year)	U, MD 32. Registrar's	Signature 1	11 PENN	STREET, B	ALTIMORE	, MARYLAND	, 21201
PHMH 17 Re	gistra	r	SEP 0 7	2005	ORIGIN	IAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1- State Registrar Amended 5,9/1/05, LDB, DOR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 20 ugene YUZ /Medical 4a. Facility Name of not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeak Woods Center Cambridge Dorchester 5. Social Security Number 131 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) Dec. 17, 1929 **Funeral** 6. Sex Birthplace (State or Foreign Country) 1XM 2□F 213-22-2131 Dec. 75 Director Mary land Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show Maryland 1X Yes 2 □ No Dorchester Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 713 Meadow Avenue or Items 23a 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 0 / 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. other traumatic event, the Medical Examiner 1 XYes 2 No 1947− If Yes, Give Year or Dates: 1969 Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 Widowed 4 Divorced White naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Administrative Worker U. S. Air Force other permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If item 27 is marked other
any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene David Brooks, Sr. Emma Edith Lowry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha E. Brooks/Wife 713 Meadow Avenue, Cambridge, Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dorchester MemorialPark 8/24/2005 4 Donation 5 Other (Special Cambridge, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 3a, Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arterioscieronic Discare Heavt **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the 93 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, À pe Demen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificate 2 No 1 ☐ Yes 1 Yes 2ZNO or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Matural 5 Pending within 24 hours after death. To the Funerel Director: A completely (illed in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOMAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

Registrarie Signature

THANNY

DHMH 17 Rev 1/2001

AURORA

29c. License number

1 47924

CAMBRIDGE

29d. Date signed (Month, Day, Year)

8.22.05

MD 21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are segible.

State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	Otato of Ivit		ertificate of I			eg. No.			
	Physici	an	1. Decedent's Name (First, Middle, La		2. Date of Death Month	h	ear	3. Time of				
	/Medi	cal	4a. Facility Name (If not institution, giv		ETH IRENE		1	August	21 ^{ay} 200		8:00	Ам
	Examir	ier	9025 Gue.Road	e street and number)		Damascus	r Location of Death		4c. County of Montgor		r	
	Funeral Director			ex 7. Aga □ M 2□XF	e (In yrs. last birthda 84 Yrs.	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar . 12,	Year) 1921	Birthpla Count Virg	ace (State o try) inia	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside Cit	ity Limits
	a-fsh	ctor	Maryland Montgor	mery	Damascus						1 🖺 Yes	2 XN0
	th with the 23a or 28	ai Dire	10e. Street and Number 9025 Gue. Road			10f. Zip Code 2087	2	10	Og. Citizen of Wha		try?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examination to the Invition of once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Xh If Yes, Give Year or Dates:	Ever in U.S. 13	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 → No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Black, 1 Specify:	White, e		
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. De	cedent's Usual Occupa ve kind of work done of DO NOT use retired	ation during most of work	king 1	16b. Kind of Busin	ness/Indi	ustry	
121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life	Homemaker)		Own Ho	nme		
Maryland 21215-0036	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Last)			TTO MOMENTO I		e (First, Middle, M	faiden Sumame)	me		
ryla	should be nd Mental i marked o	2	Ernest E. Hill	F 0:1				arie Camm				
	and 2 sl ealth and n 27 is r		19a. Informant's Name/Relationship (illing Address <i>(Street a</i> 5 Gue Road					Code)	
Baltimore,	Pages 1 annent of Hernard: If item		20a. Method of Disposition 1 ∆ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specification 1)		cemetery, c	position (Name of rematory or other place ed Spires	8/24/		oc. Location - Cit	-		a d
alti	permit. I Departm Importer any injure		21. Sign are of Pineral Service Lice	0		22. Name and Addres						Iu
	80589		Sofiet C	taple	11	L201 NORTH	MARKET S	T. FRED	ERICK, M	(D 2)	1701	
	Pnysician		23a. Part1. Enter the disease, or com- shock, or heart falure list only Immediate Cause (Final	one cause on each lin	e.	— A	A D				Approximate Interval Betwood Onset and D	ween
	/Medical		disease or condition resulting in death)	a. Merajt	a consequence of):	small c	el le	my co	×		10 1	M
	Examiner	ъ.	Sequentially list conditions, if any, leading to immediate	b								
	uted 1 Insit	Examiner	Cause (Disease or injury	Due to (or as a	a consequence of):					- 3		
Ö,	eath certificate be executed attending physician and for use as the burial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequence of):							
68760,	cate by	Medical		d				-		_		
ox 6	n certifi nding use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of	f deliven	v	
O. B	0 0	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown		B Ectopic pregnancy G Other (specify)			Month			'ear
S,	es that gned b	by Pł	Part II. Other significant conditions or	ontributing to death bu	it not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribu	te to the	cause of de	eath?
ord	w require been sig should t							Yes	2 □ No 3 □] Probab	bly 4 □Ur	nknown
II Record	The la ate has page 2	Completed						24a. Was an autopsy performing 1 Yes 2	prior	th?	sy findings a pletion of ca	ivailable luse of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Othe		h_(Check only one		-		
Division of	ding Phys th. After this funeral dir	\vdash	27. Manner of Death	1 ☐ Inpatier 28a. Date of Injun (Month, Day	y. 28b. Time	of 28c. Injury	4 Nursing Ho	me 5 Residen 28d. Describe how		Specify)		
Sior	r Attendin er death. rector: Afi by the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year) Injury		res 2 □No					
Ž	after death after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number o. State)	r Rural F	Route Numb	er,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medical C	29a. Certifier 1 Certifying Phr (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of and manner state	examination and/or	ath occurred at the tim investigation, in my op	e, date and place, inion, death occurr	and due to the cau red at the time, dat	ise(s) and manne e and place, and	r as stat	ed. he cause(s)	
	To the within To the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,						fonth, Da	ay, Year)			
			· ALAV	h all)	D	48184		3/22	103	5	
	5	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)					redenck	MD.	217	ol		
	Sta	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature							1		-	
	Registr	ar	Alif 2 3	2005	L	1 4						

			For State Registrar	State of Ma	arylan			of He	eaith a	nd Mer	ntal Hyg		ο r-	20112
	Physici	an	Decedent's Name (First, Middle Elizabeth Pha				inoate	01 0	Catif		Date of Deat	eg. No.2 [] th 17 2005	-	3. Time of Death 950 P M
	/Medio		4a. Fecility Name (If not institution				4b. City, 1	Town, or L	ocation of		ugust	4c. County		930 F M
			Asbury-Solomon					omons				Calv	ert	
4	Funeral Director		5. Social Security Number 227–14–9418 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2√2 F	e (In yrs. i 82	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, oril 1	^{Year)} 9 1923	Cour	place (State or Foreign ntry) ginia
	Maryland	tor	10a. State 10b. County Maryland Calve:	rt	10c. City	y, Town or Lo Solomor	cation						1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the	al Direc	10e. Street and Number 11740 Asbury	y Circle			10f. Zip	Code 588			1	^{0g. Citizen of V} United	Vhat Cour Stat	ntry? es
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or items 23a or 28e-f ehow amy injury or other traumetic event, the Medical Expirit or must be indiffical at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		11	Was Decede f Yes, spec	fy Cuban,	panic Orig , Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		k, White,	can Indian, etc. ite
21215-0036	ithin 72 hd ne. hen "netu	mpletec	15. Decedent (Specify only highest Elementary/Secondary (0-12)	college (1-4or 5	i+)	life. L	kind of worl OO NOT us	k done du	ion ring most	of working		16b. Kind of Bu		ŕ
α 2	filed v Hygie other t	e Co	17. Father's Name (First, Middle,	Last)		Secre	tary	1	8. Mother	's Name (F)		Legal/1 Maiden Sumam		ffice
Maryland	hould be d Mental marked o metic ev	To Be	Henry Faulkner 19a. Informant's Name/Relationsl			10h Mailin	a Addrasa					Maiden Sumam Darden City or Town,		
	alth an 27 le 1		Ruth Salter - s									Ill 6		
altimore,	Pages 1 and of He sout: If item		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)			lace of Disposemetery, crem ington				9/12/ tery	(1)5	20c. Location - rlingto	-	
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service	Licensee		17	Name and			Raus		neral H epublic		20676
8760,	certificate be executed / Medical Examiner / Medical Examiner ransit / Medical Property /	ical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Li	only one cause on each lir	a consequa	vence of):				ardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1∐Live birth 4∐Pregnant at 9∐Unknown	2 🗆 Fetal	death 3 🗌	Ectopic pre Other (spe					23d. Date Mor	e of delive	ery Day Year
ecords, P.	quires that the de n signed by the a uld be detached t	by	Part II. Other significant conditio	ns contributing to death bu	at not resu	ilting in the un	derlying ca	use given	in Part I.					ne cause of death?
\mathbf{r}	The law requires that the rate has been signed by the page 2 should be detache	Completed								_	24a. Was ar autopsy perform 1 ☐ Yes 2	pled? d	Vere autor rior to con eath?	psy findings available impletion of cause of
Vital	olcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitai:							heck only one	9)		
ō	ng Phye fter this ineral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of Injury		c. Injury a Work?	4 ⊑N urs t s 2 □ No	28d.		nce 6 Othe)
Division	lel or Attendi s after death. Il Director: All ad in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi		ry - At ho	me, farm, stre	et, factory,	office		28f.	Location (Str. City or Town,	eet and Numbe State)	er or Rura	l Route Number,
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the	edical (29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	g Physician: To the best of examiner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred a estigation, i	t the time, n my opin	date and ion, death	place, and occurred a	due to the ca t the time, da	use(s) and mar te and place, a	nner as stand	ated. the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	-/ 1			1	License n				d. Date signed		
			30. Name an address of person v	2/egg/ m	ath (lta-	232) /7: 5	Stript)	126	558		1	706,	18,0	7005
	15		JUHN A	4. WEIC	تجر	w	-/	RIF	= (=	FRE	SERIC	K. M	5-6	2005
	Sta Registr		31. Date filed (Month, Day, Year). AUG	1 9 2005 Negistr	s Signat	ure K	Span	E)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of	Maryland		artment of interest of the control o		Mental Hyg	iene eg. No.2	กร	2011.3
	Physici /Medic		1. Decedent's Name (First, Middle, L	owning					2. Date of Dear August 1	th	Year	3. Time of Death 4:30A M
	Examir		4a. Facility Name (If not institution, g Charlotte Hall				4b. City, Town, Charlott	or Location of Dea	th	4c. County of St. Ma		;
	Funeral Director		546 32 4750	Sex 7. 1 → M 2 □ F	. Age (In yrs. la 77	st birthday) Yrs.	If Under 1 Year Months Days			1928	9. Birthp	lace (State or Foreign 119an
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Calvert		10c. City, Lusk	Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 █️️No
	with the	Funeral Director	10e. Street and Number 648 Flagstaff Ro	ad		š	10f. Zip Code 2065	7	1	og. Citizen of W United	hat Coun Stat	itry? :es
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumetic event, the Medical Exemples must be notified at ODGE.	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? □ No		Was Decedent of f Yes, specify Cut	oan, Mexican, Pue	Specify Yes or No- nto Rican, etc.)		c, White,	an Indian, etc. white
21215-0036	d within 72 ho giene. er then "natur , tre Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		lor 5+)	16a. Deced (Give life. Welc		pation during most of we ad)	prking	B.G. a		
	ild be filed lental Hygi ked other ic event, II	To Be (17. Father's Name (First, Middle, Last Unknown Browning	-					me <i>(First, Middl</i> e, <i>I</i> Inknown	Ma <i>iden Sum</i> ame	9)	
Maryland	id 2 should lith and Men 27 Is marke treumetic	-	19a. Informant's Name/Relationship Barbara Ann Brow		e 64	19b. Mailir 18 Fla	ng Address <i>(Str</i> ee	t and Number or F Rd. Lusby	ural Route Number Maryland	City or Town, S	State, Zip	Code)
Baltimore,	Pages 1 and nent of Health int: If item 27 iry or other to		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		ate Metr	ce of Disponetery, crer	sition (Name of natory or other pla tan Fune	Aug 16 eral serv	2005	20c. Location - (
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lice		-				usch Fune	eral Hom	ne	
68760,	Physician /Medical Examiner bunian-Itausic physician and physician and street physician and physician street physician and physi	edicai Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a conseque	Ar)	mestaland	PIFFE MM L Fair	4			Interval Between Onset and Death
.O. Box 68	ath certif ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 □Fetald nt at time of dea	leath 3□	Ectopic pregnance Other (specify)	ey .		23d. Date		ry Day Year
Δ.	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions	contributing to dea	th but not result	ing in the u	nderlying cause gr	ven in Part I.				e cause of death?
Vital Records,	The law requir ite has been si bage 2 should	Completed						,	24a. Was ar autops perform	y pr ned? de	ior to con eath?	osy findings available npletion of cause of
of	ding Physicien: After this certific: funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manuer of Death 1. Natural 5 Pending 2 Accident investigati			R/Outpatien 8b. Time of Injury	28c. Inju	her: Nursing	ath <i>(Check only one</i> Home 5 Reside 28d. Describe ho	e) ince 6 Other	(Specify	
Division	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	Certification:	3 Suicide 6 Could not determine	be 28e. Place of	f Injury - At hom J. etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Sti City or Town		r or Rural	Route Number,
	e Hospita 24 hours e Funere	Medical C	29a. Certifier 1 Certifying F (Check only one)	hysician: To the buminer: On the base	is of examinatio	edge, death on and/or inv	occurred at the tivestigation, in my	ime, date and plac opinion, death occ	e, and due to the ca urred at the time, da	tuse(s) and man ate and place, ar	ner as sta nd due to	ated. the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier	M			29c. Licen:	1 00 1 1	7	od. Date signed	(Month, I	Day, Year)
7	5+1		30. Name and address of person who Manoj Mathur Ch	arlotte H	Mall Mar	yland	,		-	·/_		
Ü	Sta Registr		31. Date filed (Month, Day, Year) AUG 1	32. Reg	gistras Signatu	re K	book	9				

State of Maryland / Department of Health and Mental Hygien 2005 29144 1 - For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 12^{Day} 2005 ear **Physician** Josephine Gilbert Barrett 6:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Asbury Solomons Nursing Ctr Calvert Solomons If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) Funeral Months 1 □ M 2 🛛 F 94 044-28-3735 Director Apr 30, 1911 Penna Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d Inside City Limits ns 23a or 28a-f show MD Calvert Completed by Funeral Director Solomons 1 ☐ Yes 2X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11514 Emmanuel Way 20688 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 Yes, Give 2 No Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify White 3 ₩idowed 4 Divorced "naturet" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) I Hygiene. Drama Teacher Public School 7 is marked other traumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental F int; If Item 27 Is marked of Louis F. Paret Josephine M. Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Item 27 l P.O. Box 253 Alison Barrett (daughter) Mayo MD 21106 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 13 1 □ Burial 2 XI Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 2005 Lee Crematory Clinton, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ceremovascular accident **Physician** /Medical Due to (or as a consequence of): Examiner Sequentiary list on officers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial Box 68760, Completed by Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Ö in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, melest canco 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 \ Homicide within 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 12/05 30. Name and address of pason and completed cause of death (Item 23a) (Type, Print) Sylvia Bongers Batong, MD 11845 H.G. Trueman Road Lusby, MD 20657 32. Registres Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2005 ▶ Boon & sporter Registrar

DHMH 17 Rev 1/2001

85 BECKI		Please Type or Print in Blac State of Maryland / [k Indelible Ink. Ensure All Department of Health and Me		•
		1 - State Registrar	Certificate of Death	Reg. No.	.005 2914
Physicia /Medica	al	1. Decedent's Name (First, Middle, Last) WILLIAM ROBERT BECKER JR.		Date of Death Month Day AUGUST 18,	
Examine	er	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER	4b. City, Town, or Location of Death ANNAPOLIS		County of Death NE ARUNDEL
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bir 1 M 2 F 35	thday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	Date of Birth (Month, Day, Year) JUNE 25,19	Birthplace (State or For Country)
death with the Maryland me 23a or 28a-f show routst be rigitlised at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City L
in the Maryla or 28a-f shore	Director	MARYLAND ANNE ARUNDEL EDGEWAT	I'ER 10f. Zip Code	10g. Citize	1 ☐ Yes 2 ☐ en of What Country?
or its	by Funeral (316 ARBUTUS DRIVE 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Morried 1 □ Yes 3 □ Morried 1 □ Yes 3 □ Morried 1 □ Yes 3 □ Morried	21037 13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	ED STATES 8. Race - American Indian, Black, White, etc. Specify:
172	Completed b	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relited)	16b Kine	WHITE d of Business/Industry
ited within Hygiene. ther then " nt, the Wec		Elementary/Secondary (0·12) College (1-4or 5+) DP 17. Father's Name (First, Middle, Last)	AINTER		TRUCTION
	To Be	WILLIAM R. BECKER SR.	BARBARA Y		
123 E S			Mailing Address (Street and Number or Rural R ARBUTUS DRIVE EDGE	Noute Number, City or WATER, MD. 2	
rages I ar nent of Hea ant: If item ary or othe		1 Burial 2 Commentation 3 Removal from State	Disposition (Name of y, crematory or other place) CREMATORY 08-20-		Ation - City or Town, State
permit. rages Depertment of I Important: If it any injury or o		21. Signature of Funeral Service Licens	22. Name and Address of Facility GEORG 2973 SOLOMONS ISLAND	GE P. KALAS	
Princip Co	ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of the conditio	<i>y</i>		
ed by the ettending physi	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	d. Date of delivery Month Day Year
signed by		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death
ine taw requires thet the death certificate life has been signed by the ettending physpage 2 should be detached for use as the	Completed			performed?	24b. Were autopsy findings avail prior to completion of cause death?
i iii	e B	25. Was case referred to medical examiner?	26. Place of Death	10 Yes 2 No Check only one	1) X4Yes 2 □ No
fer death.	Certification; 10	27. Manner of Death 1 Natural 2 No Hospital: 1 Inpatient 2 EFVoul 28a. Date of Injury (Month, Day Year) 3 Suicide 4 Homicide 28b. T 28a. Date of Injury At home, far building, etc. (Specify)	ime of 28c. Injury at Work? A M 1 Yes 2 No 7m, street, factory, office 28f	5 ☐ Residence 6 [I. Describe how injury of vice of vice Location (Street and in City or Town, State) Ale Ch yrzh-1-	Number or Rural Route Number, Rd rear Broadwate
within 24 hours of To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	death occurred at the time, date and place, and	due to the cause(s) ar at the time, date and pl	nd manner as stated. ace, and due to the cause(s)
withir To th comp		29b. Signature and title of certifier Jos Sha Me en Ma	29c. License number OCME	29d. Date s	signed (Month, Day, Year)
			Type, Print) PENN STREET, BALTIMORI	E, MARYLAND	
State Registra	_	31. Date filed (Month, Day, Year) AUG 23 2005 32. Brigistrar's Signature	Book		
H 17 Rev 1/200	, 1		RIGINAL		

State of Maryland / Department of Health and Mental Hygiene. Reg. No.2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $2\overset{\circ}{1}^{a}$ 2005 Joseph Gaines Carley, Jr. 2:07 A August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1749 W. Regents Park Rd. Crofton Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Year) Nov. 14,1920 5. Social Security Number 7. Age (In yrs. last birthday): 6. Sex 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Months 423-12-6725 84 Director Alabama Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28e-f shov traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1749 W. Regents Park Rd. 21114 USA death Funerai 12. Was Decedent Ever in U.S. Ammed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1942-67 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after nent of Health and Menta! Hygiene. int: If Item 27 Is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>م</u> Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Officer 5+ U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charlott Grauer Joseph Gaines Carley, Sr. Maude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deportment of Health a Important: If Item 27 Is any njury or other tra once. Denise Carley / daughter 1749 W. Regents Park Rd. Crofton, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery 11/01/2005 Arlington, VA. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens e 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Retween Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenc Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery atten 3 Ectopic pregnancy jo Month 4☐Pregnant at time of death 5 Other (specify) signed by the all d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Xes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death Check onli one Hospital: Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient = 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 135848 address of person who completed cause of the (Item 23a) (Type, Print) Howard K. Schultz, Jr. M.D. 1438 Defense Hwy. #201 Gambrills, MD. 21054 31. Date filed (Month, Day, Year)
AUG 2 3 20 2. Registrar's Signature 2 3 2005 Registrar

Box 68760, Division of Vital Records, P.O.

29147 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Caffes Georgia Jean August 20, 2005 7:40 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17970 Dumfries Circle Olney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗵 F Yrs. 577-42-3321 73 Director 18, 1931 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examinational to notified at 1 ☐ Yes 2 XNo Maryland Montgomery Olney Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17970 Dumfries Circle 23a 20832 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 □ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specifyhite ģ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Communications permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: if item 27 is marked othe any injury or other *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Peter Caffes Constandena Papanastou 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter J. Caffes, Jr./Nephew 11519 Bucknell Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 22 August 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 2005 Alexandria, Virginia Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd, W, Silver Spring, مرحم MD 20901 Dun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Acute Myeloid Leukemia Months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit Due to (or as a consequence of) Physician/Medical nse s IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day ₽ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) 1 Tyes 2XXNo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) August 22 - marth 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 Orleans St., #289, Baltimore, MD 21231 Judith Karp, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State 2 3 2005 Registrar

			1 - State of Maryland / Department Certificate Certificate	t of Health and M e of Death		ene 2005	29148
	Physici		Decedent's Name (First, Middle, Last) CLARA, FLORENCE CARTY		2. Date of Death Month August 2	0, 2005 ear	3. Time of Death 10:30 P M
	/Medic Examin		1 / 77 1 0	Town, or Location of Death		4c. County of Death Frederic	
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 212-14-6562 1 M 2XJF 84 Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,) Mar . 14,	9. Birthi (ear) 921 Mary	place (State or Foreign
	ryland thow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				Od. Inside City Limits
	with the Ma a or 28a-f s	Directo	Maryland Frederick Thurmont 10e. Street and Number 14 Walnut Street	Code 21788	10	g. Citizen of What Cou	1 \ Yes 2 \ No ntry?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "netural", or Items 23a or 28a-f show aumatic event, the Maclical Exacultratinal by mullind at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes, Spec 1 Woldowed 4 Divorced 1 Yes, Give 1 Yes, Give 1 Yes 2	ent of Hispanic Origin? (Spe ify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.
Maryland 21215-0036	within 72 hour 8ne. than "netural re Mudical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machin	k done during most of worki e retired)	ing	3b. Kind of Business/In	dustry
land 2	uld be filed Aental Hygie rked other tic event, ti	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name			
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 le marked any Injury or other traumatic ex 900.9.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or Rura Trail, Fairf			Code)
altimore,	Pages 1 ment of He ent: If iten ury or oth		20a. Method of Disposition 1	ther place)		oc. Location - City or To hurmont, Ma	
Balt	permit. Departn Importe any Inju		Joseph Kieley / 615 EAS	d <mark>Éddre Baifleil</mark> y & ST MAIN STREE	T, THURM	ONT, MD 21	
8760,	Physician and ph	dicai Examiner	shock, or heart tallwe. Eist only one cause on earline. Immediate Cause (Final disease or condition resulting in death) a	Feart F Heart Su	allu		Approximate Interval Between Onset and Death 10-year
.O. Box 68	ath certifi ttending or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre			23d. Date of delive Month	ery Day Year
Δ.	tuires that the de n signed by the a lid be detached f	by	Part II. durer significant conditions continuing to death out not resulting in the underlying ca	iuse given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
al Records,		Completed	avenia		24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
Division of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification; To Be	1 A Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation M	8c. Injury at Work? 1 □ Yes 2 □ No	me 5 A esiden 28d. Di scribe how	ce 6 Other (Specifinity occurred	
<u>></u>	pital or Attendous after deathous after deatheral Director:		4 Homicide determined 229. Place of injury - Actione, farm, street, factory, building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a	W.	City or Town,	State)	
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	Medical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurre	ed at the time, date	se(s) and manner as s e and place, and due to I. Date signed (Month,	the cause(s)
	F 3 F 5		· Cla Court (MS)	D18705		8/23/0	5
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Carroll, MD 310 SOUTH SETON AVENUE, 31. Date filed (Month, Day, Year) Registrar's Signature	EMMITSBURG, N	MARYLAND	21727	
	Sta Registr		AUG 2 3 2005				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Pauline Vercelletto Corsico August 19, 2005 6:15 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Annapolitan Assisted Living Community Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Days Hours Director 119-14-3118 93 New York, NY Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28a-f show other traumatic event, the Nedical Examinat must be notified at MD Anne Arundel Annapolis Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 84 N. Old Bottom Road 21401 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. Ih and Mental Hygiene." In 7 Is marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Garment Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Vercelletto Aurellia Cavagnaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 is Augustus Corsico/ Son 28 Oak Knoll Road Menham, NJ 07945 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ott 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemtery 8/23/2005 Woodside, NY ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dehydrahon imenth /Medical Due to (or as a ornsequence of) Examiner Dementia 54 con Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by Leval Failure Checonu 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 2 No 1 Tes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 2 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) provon DOO 616 88 08/20/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dibonato Douve Chester mo 21619 Rupal Rashmikant Desai MD 2108 31. Date filed (Month AUG 2 2 32. Resstrar's Signature State 2005 Registrar

			1 - State of Maryland / Dep	partment of Health and Mental Hertificate of Death	ygiene 2005 29150
	Physici		1. Decedent's Name (First, Middle, Last) James E. Clise	2. Date of I Augus	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 16621 Oceanview Lane	4b. City, Town, or Location of Death Frostburg	4c. County of Death Allegany
	Funeral Director		5. Social Security Number 217-42-6220 6. Sex 120 M 2 F 61 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of E (Month, I	9. Birthplace (State or Foreign Country) Maryland
	faryland show	or	Usual Residence of Decedent 10a. State MD 10b. County Allegany Frostbu		10d. Inside City Limits 1 ☐ Yes 2☐ No
	with the Maryland 3s or 28e-f show If by notified at	I Director	10e. Street and Number 16621 Oceanview Lane	10f. Zip Code 21532	10g. Citizen of What Country?
ဖွ	72 hours after death with the Maryland naturel', or items 23s or 28e-1 show lites Examiner must be notified at	Funeral	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 14. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 15. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Specify Yes or Information of Hispanic Origin? (Specify Yes or Information) 1 □ Yes 2 No Specify:	Specific
Maryland 21215-0036	72 hours "naturel", olical Exp	ieted by	3 Unidowed 4 Divorced Year or Dates:	cedent's Usual Occupation we kind of work done during most of working . DO NOT use retired	Specify: White 16b. Kind of Business/Industry
12121	e filed within Il Hygiene. other then	Completed	Elementary Secondary (0-12) College (1-4or 5+) Auto	Body Technician	Automobile Dealer
yland	should be find Mental Find Men	To Be	17. Father's Name (First, Middle, Last) John Stanley Clise	18. Mother's Name (First, Midd Mae (Dreyer) Clise
	d 2 s h ar 7 ts treu		Cassie (McMillian)Clise 166	iling Address (Street and Number or Rural Route Num 521 Oceanview Lane, F	rostburg, MD 21532
Baltimore,	nit. Pages 1 and bartment of Healt ortent: if item 2 injury or other g.		4 □Donation 5 □Other (Specify) Frostbu	position (Name of Park Park Sep 1'0 arg Mem. Park Sep 1'0	
Balt	permit. Departn importe any inju		Dogod & Hate	22. Name and Address of Facility Hafer F 1302 National Hwy.,	LaVale, MD 2:502
68760, <	Physician /Medical Examiner	edicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	the lung with	retastasci 7 2 7201/ ernal v tression
.O. Box 68	The law requires that the death certificate be executed the bas been signed by the attending physician and cage 2 should be detached for use as the burial-transity.	by Physician/Medi		B Ectopic pregnancy	23d. Date of delivery Month Day Year
Δ.	quires that t n signed by ald be deta		Part II. Other significant conditions contributing to death but not resulting in the	, , ,	d tobacco use contribute to the cause of death? Yes 2 \(\Dagger \text{No} 3 \(\Dagger \text{Probably} 4 \(\Dunknown \)
Recol		Completed		24a. We aul per	topsy prior to completion of cause of death?
on of Vital Records,	ng Physicien: fter this certific ineral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 EP/Outpati 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	26. Place of Death (Check only ient 3 DOA Other. 4 Nursing Home 5 Record of 28c. Injury at 28d. Describ.	
Division	는 High	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location City or T	(Street and Number or Rural Route Number, own, State)
	the Hospitei hin 24 hours a the Funerei I npletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of the best of my knowledge, deal of the best	ath occurred at the time, date and place, and due to th investigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and tille of pertifier Plana Land Control of Contr	29c. License number (4.) 0 - 17526	AUGUST 30, 2005
	3+1		30. Name and address of person who completed cause of death (Item 23a) (Type John N. Mehanna, 921 Seton Dr.	e Print) , Cumberland, MD 2150	02
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 7 2005 32. Figistrar's Signature	Coerte	

State of Maryland / Department of Health and Mental Hygien 2005Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** 13:30 M Sue Cook Janet 05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Sacred Cumberland Hospita HearT If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** Country Min. Oct 20. Months Days Hours 1 ☐ M 2 🖫 F 506-54-1230 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at Allegany MD Cumberland Be Completed by Funeral Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Washington Street 21502 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or ite 1 Never Married 2 Married 1□Yes 2☐No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educator school other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **Duane Zastrow** Laurine Zastrow ျှ 19a. Informant's Name/Relationship *(Туре, Print)* **Gary Cook** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 600 Washington Street Cumberland MD 21502 husband 20b. Place of Disposition (Name of cametery, crematory or other place)
Shelby Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2/2005 Shelby IΑ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature > Funeral Service Licens 22. NamScarbetts Putretal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final disease or condition resulting in death) nolargiocarenoms Physician 4/40 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to infine dialecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ arcinoms 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a. Was an autopsy performed 1 Yes 2 NO Hospitel or Attending Physicien: 25. Was case referred to medical funeral director 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1. Impatient 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 3 - Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 35/35 d cause of death (Item 23a) (Type, Print) 30. Name and address of person who Seton D-Camberland 31. Date filed (Month, Day, Year) SEP 0 32. Palistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cupelli Physician Phyllis J. Aug. 10, 2005 10:05pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Forest Haven Nursing Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 169-26-4437 1 □ M 2 🔀 F 73 **Director** 2/17/1932 Smithfield, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at MD Baltimore Director Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 106 Glenwood Avenue 21228-3442 USA Items 23a Funerai 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ð Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within to f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Palmer Whoolery Nellie Sutton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emile Cupelli, Jr. / Husband 106 Glenwood Avenue Baltimore, Md 21228 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Evergreen Mem.Pk.8/15/2005 Point Marion, PA * 4 □ Donation 5 □ Other (Specify) 21. Signature PHILIP Addess FINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2+ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of): Box 68760 Physician/Medical attending IF FEMALE. **9**Sn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours aff To the Funeral Discompletely filted in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Aug.11,2005 of all 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md 21208 Tasmeen Lakhani MD 7220 Park Heights Avenue 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State Registrar SEP 0 7 2005

ORIGINAL

			For State Registrar		State of Maryla		artment of H <i>rtificate of L</i>		d Mental Hy	giene	005	29153
				(First, Middle, Last	1)				2. Date of De		-	3. Time of Death
	Physici /Medio		Sarah Ja	ne Davis					Month 8	19	Year 05	16:30 P M
	Examin	er	4a. Facility Name (If	. 5	,		4b. City, Town, or		ath		County of Death	
				g Village		(Frostbu	ırg If Under 24 H			Allegan	
	Funeral Director		5. Social Security Nu 214-07-470 Usual Residence of	102	M 200 F 7. Age (in y	rs. last birthday) Yrs.	Months Days	Hours M			9. Birth Cou Mary	place (State or Foreign intry) land
	and		10a. State	10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	Mary f sho	5	Maryland	Allegan	Fro	stburg						1 X Yes 2 □ No
	the	Director	10e. Street and Num	abor		stourg	10f. Zip Code			10g. Citize	en of What Cou	intry?
	13a o	<u></u>		03 Mount	Pleasant Street		21532-			U.S.A		
	deati	Funeral	11. Marital Status		12. Was Decedent Ever in		Was Decedent of Hi	spanic Origin?	(Specify Yes or No		4. Race - Amer	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show avant, the Medical Exempter must be inclifted ut	by Fu	1 Never Marrie		Amed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates:	i	if Yes, specify Cuba 1 ☐ Yes 2 汉 No	n, мехісап, Ри Specify:	erto Hican, etc.)	5	Black, White	
Ö	2 hou			15. Decedent's Edi		16a. Dece	dent's Usual Occupa	ation		16b. Kine	White d of Business/le	
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yla	2 should be and Mental is markad (isumatic av	၉	Edward De						ıma Gatehoi			
Nar	ges 1 and 2 should it of Health and Men it itam 27 is marks or othar traumatic		19a. Informant's Na				ng Address <i>(Str</i> ee <i>t a</i> unt Pleasant S			er, City or	Town, State, Zi	
	1 and Health am 27 Ithar tr	3	Mary Beth 20a. Method of Disp		sister	D. Place of Dispo		meer Fro	ostburg Date		aryland	21532
10	Pages 1 ar nent of Hea int: If itam : iry or othai		1 🕊 Burial 2 🗆	☐Cremation 3 ☐I	Removal from State	cemetery, crei	matory or other place	· 1			ation - City or T	
Baltimore,	permit. Pa Departmen Important: any injury		* 4 □ Donation 21. Signature of Fur	5 Other (Specify,			emorial Park 2. Name and Addres		-Aug-2005 F	rostbu	ng Mary	land
Ba	permit. Page Department of Important: If any injury or once.			hu A	()unet		rst Funeral 1	•	Frost Ave	Frostl	ourg. MD	21532
			shock, or hear	t failure. List only o	lications that caused the de	eath. Do not ent	er the mode of dying	g, such as card	iac or respiratory a	rrest,	July IVII	Approximate Interval Between
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Box	death certil e attending id for use a	an/N	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo		Ectopic pregnancy			23	d. Date of deliv	ery
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orc	w require been sig should b	eted		~6105) IV10	TE/NG	1-1110	04 E		- 10	Yes 2 🗆	No 3 ☐ Proi	Dably 4 Dunknown
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of	Physiclan: The la r this certificate had ral director, page 2	. To	1 Yes 2 7	10	1 ☐ Inpatient 2 28a. Date of Injury	☐ ER/Outpatier 28b. Time of	IL 3 DOA	4 Paylursing	Home 5 Resident			(y)
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Division	Attending Physiclan: It death. actor: After this certific by the funeral director.	fica	2 🖸 Accident 3 🗀 Suicide	6 Could not be determined	28e. Place of Injury - A	home, farm, str			28f. Location (S	Street and	Number or Rura	al Route Number.
Ö	al or A after t Dira d in by	Certification:	4 🗌 Hornicide	determined	building, etc. (Spe	cify)			City or Tov			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funaral Diractor: After theopietely filled in by the funeral		29a. Certifier	Certifying Phy	sician: To the best of my k	nowledge, deatl	occurred at the tim	e, date and pla	ce, and due to the	cause(s) a	nd manner as s	tated.
	he Ho in 24 he Fu pletel	Medical	(Check only ;	2 Medicel Exam	ner: On the basis of exami and manner stated.	ination and/or in	vestigation, in my op	inion, death oc	curred at the time,	date and p	lace, and due to	the cause(s)
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225	727		30. Name and addre	ess of person who co	ompleted cause of death (II	tem 23a) (Type,	Print) / 10	0 1	/ /	2	11110 -	
	u .		Havit	Sidhu	ompleted cause of death (III), 925 32. Registrar's Sig	1sishop	Walsh Ke	x, 64	mberla	nd,	MIJ 2	1502
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State of Maryland / Department of Health and Mental Hygiene 200529154 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 08/20/2005 12:55 P M Arthur Sumner Doan, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 820 Boatswain Way Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day, Year) 07/29/1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 ☐ F 303-30-2145 72 Indiana **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Modical Examination of the page 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2 No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 820 Boatswain Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 158-164 1 Never Married 2 Married 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) NASA Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Anna Garber Arthur Sumner Doan, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 820 Boatswain Way Annapolis, MD 21401 Dorothy Paulson Doan/ Wife 20b. Place of Disposition (Name of cemetary, crematory or other place)
Lakemont Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 08/24/2005 Davidsonville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Fungral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Mctestati /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed 2 X No 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner sta-29c. License number D 41816 29d. Date signed (Month, Day, Year) 29b. Signature and title 2005 MD

State Registrar 31. Date filed (Month 2005



State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day ElfordH. Degcon 0047 AM 21, August 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-6-1917 Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Director Yrs. 578-05-2735 87 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Anne Arundel Shady Side Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5072 Lerch Drive 20764 USA 12. Was Decedent Ever in U.S. Amped Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W. W. II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White \$ Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Printing Bookbinder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elmer Deacon Grace Rooker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen M. DiGirolamo/ Daughter 5072 Lerch Drive, Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery | 8-26-05 Cheltenham, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 -6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** one uninia One week. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. signed by the ettending physician If be detached for use as the buria an/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 4☐Pregnant at time of death Physici 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Gunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 1100 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Impatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ₺ No 2 2 ER/Outpatient this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D51819 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 241 Anapalis MD 2/44) malta 132 Hikdas CT 7. 31. Date filed (Month, Day, Year) AUG 2 3 32. gistrar's Signature State Registrar

		•	For State Registrar	State of M	aryland /		artment of F			giene Reg. No 200	5	29156
			Decedent's Name (First, Middle)	, Last)					2. Date of Dea			3. Time of Death
	ysicia Medic		Anna Isabel	l Duguid					August	30 200	ear_	1215 PM
	amin		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, et	Location of Death	1	4c. County of		1
			LORION (a)	Rook Side	,		De	PICAMP		MAR	FOR	A
	eral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	n 9.	Coun	
Dire	ctor	-	214-12-3783 Usual Residence of Decedent		85	TIS.			9/25/19	919	Mar	yland
/land	=		10a. State 10b. County		10c. City, To	own or Lo	ocation		·		10	Od. Inside City Limits
Man,	EAU	to	MD Ha	rford	Abe	erdee	en					10X Yes 2 □ No
h with the	Sthernd	al Director	10e. Street and Number 128 Post Ro	ad			10f. Zip Code 2100	01		10g. Citizen of Wha	t Coun	try?
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23a or 28e-f show	Xamiltaff. 9	by Funeral	11. Marital Status 1 ★ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? ied 1 □ Yes 2 ☑ 1 if Yes, Give Year or Dates:		1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)			etc.
5-0 72 ho	ical	ted	15. Decedent (Specify only highes	's Education	16	6a. Dece	dent's Usual Occup	ation	uia –	16b. Kind of Busin	ess/Ind	lustry
Ithin ithin	Z.Ms.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work done of DO NOT use retired	during most of world)	king			
led w	岩		12	2		Ana	alyst			Civil Se	rvi	ce
d tal	atic ever	To Be	17. Father's Name (First, Middle, Edward B. Dug	guid				Mabel V		Maiden Sumame)		
Mar 12 sh 12 sh 12 sh 7 is m	raum		19a. Informant's Name/Relations? Ruth M. Duquid	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	1		ng Address (Street a					
e, l 1 and Healtl 9m 27	thert		20a. Method of Disposition	(DISCEL)	20h Place		Post Road		rdeen, Ma		210	
Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item	any injury or other traumatic once.	1	1 → Burial 2 □ Cremation 14 □ Donation 5 □ Other (Sp				osition (Name of matory or other plac netery	9/3/		20c. Location - City Aberdeen ,		
Baltimo permit. Pag Department Important: I	any in		21. Signature of Funeral Services	Licensee NWLVV-1	espe	22	Tarring—(Aberdeen	Sargo Fur Cargo Fur Marvlar	neral Hor nd 2100	me, P.A. 1-3399		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lin	the death. D	o not ent	er the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
Physic	ian		Immediate Cause (Final disease or condition	Mu	elad	10	alchi		frome		11	Onset and Death
/Med Exam			resulting in death)	Due to (or is	a consequenc	e of):	1919711	7.50	110111			10.1142
Lxaiii		_	Sequentially list conditions,	b			<u>/</u>					
V 3	ısıt	Examiner	cause. Enter Underlying Cause (Disease or injury	One to (or as:	a soneuquene	ie utj:						
8760, < cate be executed physician and	al-trar	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	e of):					-	
760, te be exi /sician a	buris				·							
68/ flicate	as the	edical		d.							1/-	
HECORDS, P.O. BOX 65 The law requires that the death certific attending p	for use a	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)			23d. Date of Month		y Day Year
ithe de	peyor	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	time or death	3						
that	e deta	by Pr	Part II. Other significant conditio	ns contributing to death b	ut not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the	e cause of death?
Hecords, Phe law requires that has been signed to	hould be	Completed b	Atria	1 Fibril	lation				1 🗆 Y	es 2 ₽ No 3□	Proba	ably 4 □Unknown
VITAI MEC sician: The law certificate has b	Je 2 s	Id II							24a. Was a autops perfori	syprior	to com	sy findings available pletion of cause of
	r, pa	e Co	05. Who are a found to me that						1 □ Yes			2 12 No
VITAL sician: 1	irecto	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	- all co	O	Othe	10	th Check on on			
Phys of		H 17	27. Manner of Death	28a. Date of Injur	y 28b	. Time of				ence 6 Other (5	Specify)	
nding Ith:	un e	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig		/ Year)	Injury		(? Yes 2 □ No				
DIVISION I or Attending after death. Director: Afte	by the	if co	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place of Inju	ury - At home,	farm, str	eet, factory, office			reet and Number o	Rural	Route Number,
ital or rs after el Dir	u pe	Certification;	4 Tronnelde	building, etc	(Зреспу)				City or Town	i, State)		
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific	letely fill	Medical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	g Physician: To the best of Examiner: On the basis of and manner sta	examination a	lge, death and/or inv	n occurred at the tim vestigation, in my op	ie, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manne ate and place, and	as sta	ited. the cause(s)
To th To th	moo	ž	29b. Signature and title of certified	7			29c. License	number	2	9d. Date signed (M	onth, D	lay, Year)
			() () () ()	Link	>		D	19583	, /	tuanet	3	2000
	6		30. Name and address of person	who completed cause of d	eath (Item 23a	a) (Type,	Print)	8 0	iw. Sti	reet		21001
100)		Manuel	M. La-	zati	\	MD	Ab	erdeen	Mari	1/0	ind .
Re	Stat gistra		31. Date filed (Month, Day, Year)	7 2005 32. Registra	ar's Signature		1	, ,			/	`
DHMH 17 R	•		J L., i U	1 2003	we d	1	ments.	4				
>	U+ 1/2U	J 1			OR	IGINA	L	•				ī

State of Maryland / Department of Health and Mental Hygien 2005 29157 1 - For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Т. Marie East 21,2005 August 1:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Days Hours Min. 1 April 27 Arundel Medical Center Ann Arundel 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** January17,16 Maryland 1 M 2 XF Yrs. Director 89 577-01-3508 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f ehow 10d, Inside City Limits the Medical Exactiner must be notified at Maryland Prince George 1X Yes 2 □ No Directo Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 4802 Royal Crossing 20715 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative 12 12 should be filed with and Mental Hygien 7 Is marked other th Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John A. Griffith Theresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other traum once. Steven Griffith/ Nephew 4802 Royal Crossing, Bowie MD 20715 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem | 8/26/05 Clinton, Maryland 21. Signature of Ameral Service Licensee 22. Name and Address of Facility 191 Adams Funeral Home, PA , Aguasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jund - Stage
Due to (or as a consequence of): disease or condition resulting in death) cardiomy opathy 14 con /Medical Examiner 11 Jailure Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Dementra 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Artiny Discore 24a. Was an autopsy performed? certificate 2 / No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide າ 24 hours af ne Funeral ເ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08/22 D0061688 Deor 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chrim MD mP 5 R. DESAL 2108 Di Donate Device 21619 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 4 2005 Registrar

			1 - For Stete Registrar	State of M	aryland / Depa <i>Ce</i> a	artment of H	lealth and Death	Mental Hy	/giene	005	29158	}
	Physici	ian	Decedent's Name (First, Middle, La.	st)				2. Date of D Month	eath Day	Year	3. Time of Death	_
	/Medio	cal	Marguerite Ann Evar 4a. Facility Name (If not institution, give)	4b. City. Town or	Location of Deat		ust 24,	2005 ounty of Deat	03:00 AM M	-
1	Exami	iei	316 Braddock Heights			_	rostburg			gany		
	Funeral Director		5. Social Security Number 7 6. S	ex - 7. A	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D 07-Sep-	rth ay, Year)	9. Birtt	nplace (State or Foreign untry) vland	n
	land ow		10a. State 10b. County		10c. City, Town or Lo	ecation					10d. Inside City Limits	
	e-f eh	ctor	Maryland Allegar	ıv	Frostburg						14 Yes 2 No)
	vith the	Director	10e. Street and Number	lock Heights		10f. Zip Code			10g. Citize	n of What Co	untry?	
	eath v	Funeral	11. Marital Status Apt. 312	12. Was Decedent	Ever in II S 13 1	21532- Was Decedent of Hi	ispania Origin? (C	posity Voc or N	U.S.A.	. Race - Amei	Con Indian	_
980	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "neturel", or liems 23a or 28e-1 ehow event, the Mexikcal Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces 1 Yes 2 If Yes, Give Year or Dates:	No I	f Yes, specify Cuba	Specify:	o Rican, etc.)		Black, White	e, etc.	
21215-0036	within 72 h ene. then "netu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+) (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor)	rking		of Business/I		
d 2	e filed withing Hygiene.	e Co	17. Father's Name (First, Middle, Last)		homen	naker	18. Mother's Nar	ne (First, Middle	homen			_
Maryland	s 1 and 2 should be if Health and Mental item 27 is marked o other treumatic eve	To B	Joseph Whetstone 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	Evelvn Da	yton			in Code)	
	and 2 ealth ar n 27 is ier treu		William Evans, Jr.	son		Pleasant Stre		stburg		aryland	21532	
Baltimore,	ges 1 and 2 of Health if item 27 i		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	θ)	Date	20c. Loca	tion - City or 1	Town, State	
Iţim	permit. Pages Department of Inportent: If ite any injury or of		`4 Donation 5 ☐ Other (Specify)	Frostburg Me	The second secon		Aug-2005	rostbur	g Mar	yland	
Ba	permi Depa Impo any ii		21. Signature of Funeral Service Licer	Dury	Du	Name and Address	Home, 57 l			ourg, MI	21532	
			23a. Part1. Enter the disease, or compensations, or heart failure. List only Immediate Cause (Final					or respiratory a	rrest,		Approximate Interval Between Onset and Death 9 Months	
	Physician /Medical		disease or condition resulting in death)	a	noma of the a consequence of):	ne blado	ler				9 months	
	Examiner		Conventially list annelities	b	a concequence on.							
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or minny)		a consequence of):							
	execution and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							_
68760,	icate be executed physician and s the burial-transit	dical		d								
_		Med	IF FEMALE:									
Вох	death certifii e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d	I. Date of deliv Month	rery Day Year	
P.O.	0 0 0	hysic	1 ☐ Yes 2 I No 9 ☐ Unknown	9□ Unknown	tune or death 3	Other (specify)						
Vital Records, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of degenerative a			nderlying cause give	n in Part I.		obacco use Yes 2 🛂		the cause of death?	
eco	law re as bee	Completed						24a. Was		24b. Were auto	opsy findings available	_
al R	Physicien: The lav this certificate has al director, page 2	Con						nerfo	2 No	death?	·	
Zit.	Physicien: this certific ral director.	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	26. Place of Dea					
of	g Phy er this ieral d	n: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time of	28c. Injury	r: 4 □ Nursing H	ome 5 Resi 28d. Describe		Other (Speci ccurred	fy)	+
sior	Attending in death. ector: After by the fune.	catlo	1 PNatural 5 Pending 2 Accident investigation		y Year) Injury	M 1 □ Y	es 2□No					
Division	s after d al Direct ad in by	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	eet, factory, office		28f. Location (. City or Tox		lumber or Run	al Route Number,	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one)	vsicien: To the best liner: On the basis o and manner st	of my knowledge, death f examination and/or inv ated.	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. o the cause(s)	_
	To the within To the comp	Me	29b. Signature and title of certifier	-		29c. License				igned (Month,		-
)	3 sel		1). (he	mys.)		2563	8	Cluy	But	25, 2005	tue-
	per		30. Name and address of person who of Saturina Chang				tburg,	Marvla	and	21532		
	Sta	te	31. Date filed (Month, Day, Year)	32 Ballietr	ar's Signature	4	Dourg,					_
	Registr		AUG 2 5 2	2005	we It by	osu						

			1 - For State RegistrarAMEND#14per1	H8/29/05,	ryland / Depa BMW, MoCo ^{Cer}	artment of I	lealth and Death		giene 2005	29159
	Physici /Medic		1. Decedent's Name (First, Middle, Last Jane F. Fitch)				2. Date of Dea Month August	19,2005	3. Time of Death 7:45am M
	Examin		4a. Facility Name (If not institution, give 4140 Leland St	street and number)		4b. City, Town, o	or Location of Deat		4c. County of Death Montgome	
	Funeral Director		2/3-10-0853	ox □M XXF 7. Age 84	(In yrs. last birthday) 4 Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da Januar	h 9. Birth	place (State or Foreign ntry) etroit,MI
	the Maryland 28e-f show prufffed at	rector	Usual Residence of Decedent		10c. City, Town or Lo				10g. Citizen of What Cou	10d. Inside City Limits 1 Yes 2 □ No
	th with 23e or	a Di	4140 Leland St			2081	5	i i	United State	•
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show any injury or other treumettic event, If a Medical Evar that the inclined any once.	d by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	☐ Yes 2X No	Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Black	etc. WHITE
Maryland 21215-0036	d within 72 t giene. er then "net	complete	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		(Give	OO NOT use retire	during most of wo.	rking	16b. Kind of Business/Ir Interior I	,
and	d be file antal Hy ced othe c event	o Be C	17. Father's Name (First, Middle, Last) Benjamin T. Farre	e11			18. Mother's Nar Una Si		Maiden Sumame)	
lary	2 shoul and Me is mark reumeti	ř	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	g Address (Street		*	r, City or Town, State, Zip	Code)
re, l	s 1 and of Health item 27		Farrell Cosmas / I		20b. Place of Dispos		t.,Chevy	Chase, M	D 20815 20c. Location - City or Te	own, State
Baltimore,	it. Page intment of intent: If injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ☐ cens)	Mt. Comf	ort Ceme	tery 8-	22-05	Alexandria	
Ba	Depa Impo any i		William R. 1	Sugge	51	30 Wisco	nsin Ave	,N.W. Wa	ler's Sons, shington DC	
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. <u>Chroni</u>	c Obstruct				rest,	Approximate Interval Between Onset and Death 6 Years
8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of): consequence of):					
Box 6	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delive Month	ery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co.	ntributing to death but	not resulting in the un	derlying cause giv	en in Part I.		bacco use contribute to the	
Vital Records, P.O		e Completed							sy prior to co med? death? 2 XNo 1 ☐ Yes	psy findings available mpletion of cause of 2 No
Division of Vil		To B	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	28c. Injur Wor	er: 4 🗆 Nursing H		ence 6 □Other <i>(Specif</i> ow inju r y occurred	y)
Divis	Dir Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Si City or Town	treet and Number or Rura n, State)	l Route Number,
	To the Hospitel within 24 hours a Vo the Funerel I completely filled	edical (29a. Certifier 1 Cartifying Phy (Check only one)	sician: To the best of nar: On the basis of e and manner state	xamination and/or invi	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner as state and place, and due to	ated. the cause(s)
	To the within 2 to the comple	Me	29b. Signature and title of certifier	3.00		29c. Licens			9d. Date signed (Month,	* * *
	5		30. Name and address of person o co	IMM ompleted cause of dea	ath (Item 23a) (Type. F		2033		August 19,20	005
			Peter G. Hamm M.D 31. Date filed (Month, Day, Year)	• 5530 W	isconsin A	ve,Chevy	Chase,M	D 20815		
E	Sta Registra			32. Risgistrar's	s Signature	ones?				

			1 - For State Registrar	State of Ma	rylan		rtmen tificate			Mental Hy	ygien Reg. N		20160
	Physici		1. Decedent's Name (First, Middle, Las Charles Ashley	•						2. Date of D Month	D	2005 20,2005	956 P M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of Dea			c. County of Death	
			Civista Medical (Plat				Charles	
	Funeral Director		5. Social Security Number 6. Sec. 358-19-9566	X 7. Age ☐M 2☐F	(In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min		irth bay, Year 20	1961 Geor	ace (State or Foreign try)
			Usual Residence of Decedent							эсрс.	20,		
	daryla f shov	ō	10a. State 10b. County			, Town or Lo						10	Od. Inside City Limits 1 ☐ Yes 2 \ No
	r 28a-	Directo	Maryland Charles 10e. Street and Number		v	Maldor	10f. Zip	Code			10g. C	itizen of What Coun	try?
	23a o		3431-D White Fir	Court					0602			USA	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic avant, the Medical Examination ust be indiffied at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	ver in U.:		Vas Deced f Yes, spec l □ Yes 2		spanic Origin? (n, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	lo-	14. Race - America Black, White, e Specify: Whi	etc.
2-00	"natural",		15. Decedent's Ed (Specify only highest grad	ucation		16a. Deced	lent's Usua	I Occupa	tion uring most of wo	arkina	16b.	Kind of Business/Ind	ustry
121	be filed within 72 ho ital Hygiene. id other than "natur avant, The Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. L	OO NOT us	e retired)		iking		110.0	
9	filed v Hygie other t	o C o	12 17. Father's Name (First, Middle, Last)			Mate	riai			me (First, Middle	e, Maide	US Gove	ernment
/Jan	2 should be fited within and Mental Hygiene. Is marked other than aumatic avant, The Man	То Ве	John R. Finch						Dore	tha Purv	is		
Agra	2 sho		19a. Informant's Name/Relationship (7				-				-	or Town, State, Zip	•
)とっこいじ altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic as <u>once</u> .		Brenda F. English 20a. Method of Disposition	- 31ster	20b. Pl	9/0/ lace of Disposemetery, cren					T	dywine, MD	
70	Pages nent of i int: If Its iry or o		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify							Ž005 ist 29.		acon, Geor	
atti	permit. Departm Importa any inju		21. Signature of Funeral Service Licen	9	,	22	. Name an	d Address	s of Facility	P. 0	. Bc	x 156	
⊘ m	8 9 E 8 9		Mark & I Not	aun			_		ral Home			MD 20604	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. Myo(consequence	ul In ve He	farc ext F	4100	re		ariest,		Approximate Interval Between Onset and Death
58760,	death certificate be executed attending physician and of for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	d pe ri	Chules-	en l						
O. Box 6	res that the death certification of the attending postering to be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal	death 3	Ectopic pro					23d. Date of deliver Month I	y Day Year
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جَجَ Division of Vital Recol	Physician: The law r this certificate has be ral director, page 2 sh	Completed	Nicotine abus	2						24a. Was auto perfe 1 ☐ Yes	ormed?	death?	sy findings available inpletion of cause of
∠ Eta	sician s certifi lirector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatien	· 2□1	ER/Outpatien	3□ 00	A Othe	~	ath (Check only		6 ☐Other (Specify)	
ion of	nding Phy ith. : After this e funeral d	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28b. Time of Injury		3c. Injury Work	· , renoung .	28d. Describe			<u>' </u>
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry - At ho (Specify	me, farm, stre	eet, factory	office		28f. Location (City or To	(Street a wn, Stat	nd Number or Rural 'e)	Route Number,
	the Hospi in 24 hour he Funer pletely filk	edical	(Check only 2 Medical Exam	'sician: To the best of iner: On the basis of and manner state	examinat	wledge, death ion and/or inv	estigation,	in my op	inion, death occ	e, and due to the urred at the time,	, date an	id place, and due to	the cause(s)
	To To To I	Σ	29b. Signature and title of certifier	o mn			29c	License		_		8 1 22/20	
			30. Name and address of person who d	mpleted cause of de	ath (Item	23a) (Type	Print)	poc	5768			0122100	<i>U</i> 3
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	Sta Regista		31. Date filed (Month, Ddy, Year) AUG 2 4	32. Registrar 2005	r's Signat	Sur	bout	0					

			For State Registrar	State of Maryla			Health ar		9	29161
	Physici /Medic		1. Decedent's Name (First, Middle,	FRANKE	UBER			2. Date of De	Day \SYear(3. Time of Death 7.36 Am
	Examir	ier		w Road N. W. 6. Sex 7. Age (In yrs	s. last birthday, Yrs.	4b. City, Town, o	Mount S	Hrs. 8. Date of Bir (Month, Da	Allegany th, Year) 9. Bin	thplace (State or Foreign
	Director		214-28-7195 Usual Residence of Decedent 10a. State 10b. County	/ 14	City, Town or L	ocation		04-May-	1931 Mar	yland 10d. Inside City Limits
	ith the Mar or 28e-f sl	Director	Maryland Allegation 10e. Street and Number 16905	gany Mou Dutch Hollow Road, N	unt Savaş N.W.	10f. Zip Code			10g. Citizen of What Co	1 Pres 2 No ountry?
-0036	7.72 hours after death with the Maryland *naturet", or items 23a or 28e-f show salical Exscrimet Perhalitied at	ed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 10 Yes 2 No Korlif Yes, Give Year or Dates:	vear flict	21545- Was Decedent of If Yes, specify Cub 1 ☐ Yes 22 No	Specify:	n? (Specify Yes or No Puerto Rican, etc.)	U.S.A 14. Race - Ame Black, Whit Specify: Whit 16b. Kind of Business/	e, etc.
21215-0036	withir ene. then	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most o d)	f working	state governme	
	be filed tal Hyg d other event,	Be	17. Father's Name (First, Middle, L	ast)	HORVY	equipment	18. Mother's	Name (First, Middle		
Maryland	s 1 and 2 should f Health and Men item 27 Is marke other treumatic	J.	Charles G Franken 19a. Informant's Name/Relationsh	ip (Type, Print)		ing Address (Street	and Number		er, City or Town, State, Z	
Baltimore, I	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		Annabelle Franken 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L	3 □Removal from State Recify) 20b.	Plac Roads cemetery, cre stlawn Me	MioW(Name of matory or other pla emorial Gard 2. Name and Addre	ce) ens	Mount Savage Date 29-Aug-2005 1 57 Frost Ave.	20c. Location - City or	ryland
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.O. Box 68760	death certificate e attending phy ed for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	tal death 3	□Ectopic pregnance □ Other (specify) _	у		23d. Date of deli Month	ivery Day Year
<u>α</u>	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant condition	ns contributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did t	obacco use contribute to	the cause of death?
al Records,	The ate h page	Completed	Hype	remonit	yî \$			1 ☐ Yes	osy prior to death? 2 No 1 □ Yes	topsy findings available completion of cause of
of Vital	Physicien: 7 r this certifical ral director, p	To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Ott	ner: 4 🗆 Nursi		one) dence 6 □Other (Spectors) how injury occurred	cify)
Division	l or Attending F after death. Director: After I in by the funer	Certification;	1 Natural 5 Pending investiga 3 Suicide 4 Homicide 5 Pending determine	(Month, Day Year)	Injury	M 1 🗆	rk? Yes 2⊡No		Street and Number or Ru	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	g Physicien: To the best of my kn exeminer: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tire to the	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)		Me	29b. Signature and title of certifier	eris mi	D	29c. Licens	o345	59	29d. Date signed (Month	n, Day, Year)
درى	(18)		30. Name and address of person w	vno completed cause of death (Ite	om 23a) (Type,		VE.	CUM BEI	RUAND!	MADON
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 (32. Registrár's Sign	nature	borte	1			7/3

State of Maryland / Department of Health and Mental Hygiene, 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Floyd **Physician** Month Day [11zabeth trances Augus + 13 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington COUNTY HOSP. Hagerstown Washington If Under Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 Ø F 243-82-1741 Director 56 CAROLINA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at Washington 1 Nes 2 No Md. Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 DIVISION 21740 U.S. A. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2☑No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Citi Corp. Service Customeer 2 yrg. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If Item 27 is marked of Be Sheppard Mebane George 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traignes. 225 DIVISION AVE Hagerstown Md. Floya husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Aug 20, 2005 Greensboro, N. Carolina 4 ☐ Donation 5 ☐ Other (Specify) redmont Cem. 22. Name and Address of Pacility Funeral Home 21. Signature of Funeral Service Licensee ollens 110 WEST SOUTH ST. FREDERICK, MO 21701 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Conquire Heat Failure **Physician** Chance /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in that and available that in the cause of the c Examiner lend Invition chanic The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 Mill PRAYEON Hagerstown Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	•	For State Registrar	State o	of Maryland		artment o rtificate d				ene g. No.	005	291	63
		1. Decedent's Name (First, Middle	, Last)					2	Date of Death		Year	3. Time of D)eath
Physicia /Medic			Cora	Elizabeth	For	t		A1	ugust	17	2005	5:59p	М
Examin		4a. Facility Name (If not institution	, give street and nu	imber)		·	n, or Location of			4c. Co	ounty of Death		
		Shady Grove Adv 5. Social Security Number	entist Ho	spital 7. Age (In yrs. last	hirthday		ockville ear If Under		. Date of Birth		Rockv		Foreign
Funeral Director		577-12-0789	1 M 2 🛱 F	85	Yrs.		ys Hours	Min.	(Month, Day,	Year) 191		place (State or I ntry) ington	
		Usual Residence of Decedent							cpt.12	171	Masii		
ith the Marylan or 28e-1 ehow	١	10a. State 10b. County		10c. City, T	own or Lo	ocation						10d. Inside City 1 ☐ Yes 2	
he Mi	Director	Maryland Mont 10e. Street and Number	gomery	Damas	cus	100 71: 0-				N= 0'M=	410/11 0		- <u>K</u> 140
with t						10f. Zip Coo	20872		10		n of What Cou	,	
Jeath ms 23	Funerai	10200 Johns Dri	12. Was Dec	edent Ever in U.S.	13.	Was Decedent If Yes, specify (igin? (Speci	fy Yes or No-		ted Sta Race - Ameri	can Indian,	
burs after death with the Maryla burs after death with the Maryla either again to the second of the		1 Never Married 2 Marr	Armed Fe ied 1 □ Yes If Yes, G	21 No		1 ☐ Yes 2 ☒			can, etc.)		Black, White	etc.	
	d by	3 ☑ Widowed 4 □ Divorced	Year or D	Dates:								ite	
n 72 h	Completed	15. Decedent (Specify only highes	r's Education of grade completed)	1	6a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use re	cupation one during mos stired)	t of working	, 1	l6b. Kind	of Business/Ir	ndustry	
withi iene. r than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		Attend				Monts	gomery	County	
e filled I Hyg other	Be C	17. Father's Name (First, Middle,	Last)					er's Name (i	First, Middle, M				
uld be Wenta Wenta rrked	To B	Robert Phipps					Della	a Mils	sted				
permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturany injury or other traumatic event, It a Modest 200ce.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Str	reet and Numbe	er or Rural F	Route Number,	City or To	own, State, Zi	o Code)	
and sealth m 27		Mary Jean Poole	/ Daughte	er land	10200	Johns	Drive,	Damas			and 208		
Pages 1		20a. Method of Disposition 1 Burial 2 □ Cremation		State ceme	etery, cre	matory or other	place)	8/22/2	2005				
iit. Partmer		' 4 ☐ Donation 5 ☐ Other (S		Bethe		Methodi 2. Name and Ad		-	D	amas	cus, Ma	aryland	
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Physician		Immediate Cause (Final disease or condition	only or Cause on	7		-K	rter	~ K	2000	17		Onset and De	
/Medical		resulting in death)	a. Due to	(or is a consequen	ce of):	10	/	1	1			65	1
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w requires that the death certificate been signed by the attending phended for use as the should be detached for use as the state of th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnancy birth 2 Petal de		⊒Ectopic pregna	ancv			230	. Date of deliv	,	
e deal he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ Ho		nant at time of death		Other (specif)		· · · · · · · · · · · · · · · · · · ·			Month	Day Ye	ear
d by t	Phy	9 ☐ Unknown Part II. Other significant condition	ne contributing to c	leath but not reculting	a in the I	inderhina cause	anyen in Part I		23e Did tob	acco use	contribute to	he cause of dea	ath?
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ysicie is cert direct	ToB	examiner? 1 ☐ Yes 2 ♠ No	Hospital:	Inpatient 2 ☑ER	/Outpatie	nt 3□ DOA	Other		5 ☐ Reside		Other (Speci	fy)	
neral		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	28a. Date (Mor	of Injury 28 oth, Day Year)	b. Time o	of 28c. I	Injury at Work?	28	d. Describe ho	w injury o	ccurred		
eath. or: A	catic	2 Accident investig	gation				1 Yes 2 🗆						
or Att	Certification:	4 Homicide determine	ined 28e. Plac	e of Injury - At home ling, etc. (Specify)	i, farm, st	reet, factory, off	ice	28	f. Location (Str City or Town,	eet and N , State)	lumber or Rur	al Houte Numbe	91,
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a, Certifier 1 Certifyin	o Physician: To th	e best of my knowle	dge deat	th occurred at th	e time, date an	nd place, and	d due to the ca	use(s) an	d manner as	stated.	
e Hos 24 h e Fur letely	edical	(Check only 2 Medical one)	Examiner: On the I	basis of examination	and/or in	vestigation, in r	ny opinion, dea	ith occurred	at the time, da	te and pla	ace, and due t	o the cause(s)	
	0	29b. Signature and title of certifie		//	. /	29c. Lic	ense number		29	d. Date s	igned (Month,	Day, Year)	
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State of Maryland / Department of Health and Mental Hygien 2005 29164 Certificate of Death Req. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2005 James Gardner Fowler August 12 6:18 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1**X**M 2□F Months Director 220-26-2555 April 19, 1926 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Show item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Cosimano Place 20778 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: 1943–46 Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 72 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) carpenter construction is 1 and 2 should be filed vol Health and Mental Hygie item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Fowler Daisy James M_{-} Stinnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace Anne Fowler, wife 1001 Cosimano Place, West River, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If itel
any injury or ott Mt. Harmony Cemetery 08-16-2005 Owings, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility elleon Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acute disease or condition resulting in death) music /Medical Due to (or as a consequence Examiner CAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ eq Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? 1 Yes ⊅ No 2 No Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ٩ 1. ☐ Linpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen BAM C 10+1 31. Date filed (Month, Day, Year) 32. Registras Signature State Registrar

		í	1 - For State Registrar	State of M	aryland		artment of H		nd Mei		ene200	15	29	165
	Physici		1. Decedent's Name (First, Middle, I Albert M.	ast) Goff					2.	Date of Death Month		ear	3. Time of	Death
E	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or Knoxvi		Death		4c. County of Washing			
	Funeral Director				6 (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, Dec. 4,	Year)	Count	virg	
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation					10	d. Inside C	ity Limits
	a-f sh	ctor	Maryland Washi	ngton		Kno	xville						1 🗌 Yes	2 X No
	or 28	Director	10e. Street and Number				10f. Zip Code				g. Citizen of Wha		-	
	eath v	Funeral	724 Valley Ro	ad 12. Was Decedent	Ever in U.S.	13 \	21758		in? (Specifi		United :			
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If I tem 27 is marked other then "natural", or Items 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at	þ	1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Forces?		5	Was Decedent of H f Yes, specify Cuba I□ Yes 🏧No	Specify:	Puerto Ric	an, etc.)		White, e	tc.	
2-0	72 ho natur	Completed	15. Decedent's (Specify only highest of	Education grade completed)		(Give	lent's Usual Occup	durina most o	of working	1	6b. Kind of Busin	ess/Indi	ıstry	
7	within ene. then	dwc	Elementary/Secondary (0-12)	College (1-4or	5+)		oo NOT use retired osives En		r		Blasti	16		
<u>5</u>	other vent, I	Be Co	17. Father's Name (First, Middle, La	st)						First, Middle, M	aiden Sumame)	-0		
ylar	ould b Menta arked	ToE	Milton H. Goff						nda S					
Maryland 21215-0036	nd 2 shualth and 27 is m		19a. Informant's Name/Relationship Edith E. Goff /				ig Address <i>(Street a</i> Valley Rd					te, Zip (Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other tre ance.		20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3		cem	netery, cren	sition (Name of natory or other place		Date		Oc. Location - Cit			n d
E T	nit. Partmer ortent injury g.		*4 □Donation 5 □ Other (Special Signature) of Funeral Service Lie	•	Kest		n Memoria				rederic neral H	-	агута	.na
<u>~</u>	Departiment of the position of		Yourtnew (Stauffe	7	1	100 North	Maple	e Ave	., Brun	swick, l		1716	
			23a. Rarti. Enter the disease, or co shock, or heart failure. List on	mplications the caused ty one cause on each li	the death.	Do not ente	er the mode of dyin	g, such as ca	ardiac or re	espiratory arres	st,		Approximat Interval Bet Onset and	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Atlant	a consequer	e proper	lascular !	Di socos						
	Examiner		Commencially lies and distance	n Diabed	s MU	itus							3041	5
	sit sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):							2	
	axecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):							30713	5
8760,	licate be executed physician and is the burial-transit	dlcal		d										
9	ertifica ding ph		IF FEMALE:	23c. If yes, outcome	26									
. Box	that the death certific ed by the attending p detached for use as t	lclan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)				23d. Date o Month			Year
P.O.	at the d by the etache	Phys	9 🗌 Unknown	9□ Unknown						60. Biles				
Vital Records,	The law requires that the death certifi sie has been signed by the attending l age 2 should be detached for use as	Completed by Physician/Me	Chrone Lun; Dis	ea Se	out not resulting	ng in the ur	nderlying cause give	en in Part I.			acco use contribu s 2 □ No 3 [Te to the	1.	Unknown
eco	has bee	nplet	Righeral Vascula	, Digent						24a. Was an autopsy	prio	r to com	sy findings pletion of c	available ause of
E E		e Cor	25. Was case referred to medical					00 81	10-1-10		⊘ No 1□	Yes 2	!□ No	
	Physicien: r this certifica ral director, i	To Be	examiner?	Hospital:	ent 2□ER	VOutpatien	t 3 DOA Othe	0.5		Resider	nce 6 Other	Specify)		
Division of	After After fune	tion:	27. Manner of Death Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Da	y Year) 28	8b. Time of Injury	28c. Injun Worl M 1 🗆	at at	28d		v injury occurred			
ivisi	l or Attending after death. Director: Afte in by the fune	Certification:	3 Suicide 6 Could not determine	be 28e. Place of In	ury - At home c. (Specity)	e, farm, str	eet, factory, office		28f.	Location (Stree City or Town,	eet and Number of State)	r Aural	Route Num	nber,
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	edge, death	occurred at the tim	ne, date and	place, and	I due to the car	use(s) and manne	r as sta	ted.	
	the Ho in 24 h the Fu spletely	Medical	one)	aminar: On the basis of and manner st	f examination ated.	n and/or inv			occurred :					s)
		2	29b. Signature and title of certifier	- 1 4		_	29c. License			29	d. Date signed (A	fonth, D	ay, Year)	
	13x		30. Name and address of person wh	Depth Mi	E.F. 1. 1 V BP	3a) (Type.		569	65		8/1	4/1	5	
-	\		Stoplen J. K.			, , ,, ,	,	54.	Has	griston	mo	21	140	
	Sta Registr		31. Date filed (Month AUG Zr)2	2005 32. Sqistr	ar's Signatur	* A	Antition							

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 2005° MARVIN SYLVESTER GRAY, SR. 12:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES RESIDENCE. 2716 HAMMOCK COURT BRYANS ROAD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours FEBRUARY 25,1948 1**▼**M 2□F MARYLAND 216-50-9721 58 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral', or Itams 23s or 28a-f show 1 XYes 2 No **Funeral Director** MARYLAND CHARLES BRYANS ROAD 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 2716 HAMMOCK COURT 20616 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 196 1 Yes 2 □ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1967-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: 3 □ Widowed 4X Divorced BLACK 1977 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FOOD SERVICE 12TH GRADE condary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT COOK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental FRANCIS GRAY la marked CLARA L. GRAY GRAY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARVIN S. GRAY, JR. / SON 2716 HAMMOCK COURT, BRYANS ROAD, MARYLAND itam 27 I other tra Health 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State permit. Pages 1
Department of H
Important: If ita
any injury or otl
once. cemetery, crematory or other place) W Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEMETERY AUGUST 29,2005 CHELTENHAM, MARYLAND 4 □Donation 5 □ Other (Specify) LAULA C. THORNION JOHNSON MO0583 22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCED Pnysician COL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed Due to (or as a consequence of): burial-Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Ponknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 Yes 2 PNo Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home + esidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 - Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours a To tha Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier perse 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 2:36 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 104/15 MOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 22, 1950

9. Birthplace (State Country)
New York **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Days Hours Months 1₩ M 2□ F Min 55 Yrs Director 120-40-6991 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show freumetic event, the Madical Examiner rust be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Street 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö 1904 Whiteford Road or items 23g 21154 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 Widowed 4 Divorced 'neturel', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Convenience Store 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Adolph Gorhan Agnes Przybal 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is Susan Gorhan (Spouse) 1904 Whiteford Road, Street, Maryland 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdns 8/26/05 Aberdeen, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility any Tarring-Cargo Funeral Home, P.A. 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SEPSIS 3 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FAILURE, CHRONIC Sequentially list conditions, it any, leading to infine fiat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 WEEK Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the ģ Part II. Dthar significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by HEPATO (ELLULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate 1 Yes 2 No Division of Vital 2 🗆 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl. one examiner' Other: ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending after death. death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLFEST BALTEMORE CORDONE MICHAEL 600 State 2005 Registrar

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an	n	Decedent's Nam		, Last)	70			21				2. Date of De Month	Day	, 000 Y	ear	3. Time of Dea
al	al -	A. Parille Manager	Lale		R.		(-	Glover		Lasation		August		2005 County of	Deeth	11:32 P
	r	4a. Facility Name (Town, or I		or Death			,		orge's
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 4:15 A George Gutmann 23, Henry 2005 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany County Nusing and Rehab. Center Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/18/1926 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M M 2 □ F 79 Yrs. Director 163-30-3415 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or items 23s or 28s-1 show treumstic event, the Medical Examinar must be notified at MD Allegany Director Cumberland 1 TXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 Frederick Street 21502 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Supervisor Tire and Rubber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be George Gutmann Margarate Geisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Elisabeth Gutmann / wife 1211 Frederick Street, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of h permit. Pages Department of I Important: If it any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Luke's Cemetery 08/25/2005 Cumberland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructive Lung R **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and ned for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗆 No 1 ☐ Yes 2**X** No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide hours after within 24 hours a To the Funerel D 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0014865 August 24, 2005 30. Name and address of person who complete hause of death (Ite of 23a) (Type, Print) 43 500 Memorial Avenue, Cumberland, Maryland 21502 Robustiano J. Barrera, M.D., 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

DHMH 17 Rev 1/2001

Registrar

AUG 2 4 2005

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Gentry, Jr. Allen Frederick AUGUST 2005 1350 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours 1⊠M 2□F Yrs. Maryland 213-40-4039 09/15/1942 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 28a-f show treumatic event, the Medical Examinar must be notified at 1 No Yes 2 No Director Cumberland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 21502 USA 230 435 Columbia Street Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: If item 27 is marked other the any injury or other treum- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 📉 No 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louise Markeisick Gentry, Sr. Nancy Allen Frederick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 435 Columbia Street, Cumberland, Maryland 21502 Barbara S. Gentry / wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 □ Burial 2 X Cremation 3 □ Removal from State 08/24/2005 Cumberland, Maryland Cumberland Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) Adams Family Funeral Home, P.A. 21. Signature o Fune al Service Licensee 22. Name and Address of Facility 404 Decatur Street, Cumberland, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypoventilitory Syndrome with probable hypercarbia 1 year Pnysician /Medical Due to (or as a consequence of): **Examiner** Morbid Obesity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence of Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, p 3 Probably 4 Unknown 1 ☐ Yes 2 🛣 No Chronic Renal Insufficiency Be Completed Recent E. Coli Septicemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2X No 2XXER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; After 1 X Natural 5 Pending 1 TYes 2 🗆 No death. investigation 2 Accident **Director:** 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054987 د ئ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 Seton Drive, Cumberland, Maryland Christopher Vagnoni, M.D., 32. Re strar's Signature 31. Date filed (Month, Day, Year) State AUG 2 4 2005 Registrar

			For State Registrer	State of Marylan		artment of H			giene 0	5 29171		
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	/Medic Examin		4a. Facility Name (If not institution, give s Shady Greve Ad	street and number)	ital	4b. City, Town, or	Location of Dea		4c. County of	of Death		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yis.		If Under 1 Year Months Days	If Under 24 Hi Hours Mii		y, Year)	Birthplace (State or Foreign Country) CAMBODIA		
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	ty, Town or Lo	ecation				10d. Inside City Limits		
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a Z	2 should be and Mental is marked commetic ev	2	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a	and Number or i					
	and 2 valth an 127 is or trou		KIMSAY K. SUON/I			9 RELIANT	DR., G					
Baltimore,	Pages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	cemetery, cre	osition (Name of matory or other place CREMATO)		Date 2005	RIVERDA	City or Town, State		
Balti	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other treumetic events.		21. Signature of Funeral Service Livers	All. a (11)	C	2. Name and Addres HAMBERS F 801 CLEVE	UNERAL	HOME & CE	REMATORIU RDALE, MI	JM,P.A. D. 20737		
	- 11		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deal						Approximate Interval Between Onset and Death		
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Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta	al death 3[☐Ectopic pregnancy			23d. Date Mon	e of delivery oth Day Year		
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<u>α</u>	uires that t signed by Id be detac	by	Part II. Other significant conditions co.	ntributing to death but not res	en in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Hannown					
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Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	18 Rises of Injury. At home farm street factory office					8f. Location (Street and Number or Rural Route Number, City or Town, State)			
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	To the within To the compl	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)		
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			30. Name and address of person who co	ompleted cause of death (Ite	00.	· Madia	0001	Or. P.	Lulla .	MD 20850		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 2 3 20	33 Registrar's Sign	nature	alles	x Centre	r. locac	reville	111) augs U		
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State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 04:12 Augus + 2005 James Edward HAWKINS Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital tf Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 17,1962 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Min. 1 ☑ M 2 ☐ F Director Maryland 212-82-4724 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits ahow 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director 28a-1 Hagerstown Maryland Washington 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number ö 21740 U.S.A. or Itams 23e 709 Washington Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "natural", or Ital 1 ☐ Yes 2 XNo tf Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward Hawkins Sr. Anne Culp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important; If itam 27 ia n any injury or other traum once. Robin Morrison - Friend 14872 Robinhood Circle, Greencastle, Pa. 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 8/25/05 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 first & Wisher 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) on Ventolativ Kesbiralovy Physician /Medical Renal Failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Seinurcs as the burial-transit that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2[] No 1 Yes 2 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) ner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O 00062223. 30. Name and address of person who completed cau of death (Item 23a) (Type, Print) 340 1H-0 Jolarun 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lucille B. Hill August 2005 11:55 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Forestville 6612 Insey Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 XF Yrs. **Director** 95 July 19, 1910 Louisiana 578-32-6584 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "netural", or Items 23a or 28e-f show the Medical Examinar must be exclibed at 1 ☐ Yes 2 ☐ No Prince George's Forestville Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 United States 6612 Insey Street filed within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Black þ Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. Military Personnel Clerk Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bettie Ann Davis Edward Webster Bates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce L. Lyerly - Daughter 6612 Insey Street, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 8/18/2005 Brentwood, MD * 4 ☐ Donation, 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 OBN 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if hear failure. List only one cause on each line. Approximate Interval Between Immedia use (Final disease or condition resulting in death) Onset and Death **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 [X]No 24a. Was an autopsy performed? Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 X No ^L 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) ms D0055120 August 17, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Palmer, M.D. 1328 Southern Ave., S.E. #310, Wash., DC 20032

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) AUG 2 3 2005 Registrar's Signature

			For State Registrar		State of	Marylar				lealth a Death		ental Hy	giene	A A	29174	
	Physici /Medic		1. Decedent's Name (A Dorothy C.		st)							2. Date of Domestin	Day	2, 2005 Year	3. Time of Death 08:15 PM M	
Exami			4a. Facility Name (If no	_				4b. City,		Location of				County of Dea	ith	
			Frostburg Vi				In ad birdball	If Under		rostbu		0 D-11 -f D		legany		
	Funeral Director		5. Social Security Num 214-24-6318 Usual Residence of De	1	M 2 1 1 7.	93	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D. 02-May-	1912	C	thplace (State or Foreign ountry) yland	
	yland how		10a. State	0b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Ba-f s	ctor	Maryland	Allegar		Frost			_						1 XYes 2 □ No	
	with th	Director	10e. Street and Number	_				10f. Zip					-	zen of What Co	ountry?	
	eath v	eral	11. Marital Status	100 Hone	ysuckle Lan			215		ispanic Ori	igin? (Spe	cify Yes or N	U.S.A	14. Race - Ame	erican Indian	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 236 or 28a-f show other treumetic event, the Medical Exameration and be notified at	by Funeral	1 Never Married 3 Wildowed 4		Armed Force 1 Yes 2 If Yes, Give Year or Date	es? NNo		If Yes, special ☐ Yes		Specify:		cify Yes or N Rican, etc.)		Black, Whi	te, etc.	
5-0036	2 hou	ted	15	. Decedent's Ed	ducation		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	Whit nd of Business		
215	thin 7. e. "n Medi	Completed	(Specify Elementary/Secondary	only highest gra ary (0-12)	College (1-4	or 5+)	(Give life.	kind of wo DO NOT u	rk done d se retired	during mos f)	t of workir	ng				
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and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (Fir									(First, Middle	, Maiden	Sumame)		
aryland 2121	2 should be filed withir and Mental Hygiene. Is marked other then eumetic event, In. M.	L 2	Henry J. Sw		Tyne Print)		19h Mailir	na Address		Edna		l Boute Numb	ner City o	r Town, State,	Zin Codel	
S	and 2 s ealth an n 27 ls i		Margaret He		niece		210 Bra			4	Frost		_	faryland	21532	
re,	item 27 l		20a. Method of Dispos			l .	Place of Dispo			1		ate		cation - City or		
altimore,	Pages nent of unt: If its ury or o		1 ☐ Burial 2 🕱 0 `4 ☐ Donation 5			ate	nberland			1	23-Aı	ıg-2005 (Cumbe	rland Mai	ryland	
Balt	permit. Pages 1 an Deportment of Heal Important: If item 2 any injury or other once.		21. Signature of Fune	ral Service Licer	Dur	1				ss of Facilit Home ,	-	ost Ave.	, Fros	tburg, M	D 21532	
			23a. Part . Enter the	disease, or com	plications that cau	sed the deat	th. Do not ent	er the mod	le of dyin	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between	
	Pnysician	(i. i	Immediate Cause (Fir disease or condition				my	carr	hil	3ng	ard.	in			Onset and Death	
	/Medical Examiner		resulting in death)		Due to (or	as a consec	quence of	,		0.5					- rouge	
	Lxammer	<u></u>	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of Due to your and property) Sequentially list conditions.						VISA	east				years		
	ted	Examiner	cause. Enter Underlyi Cause (Disease or inju	ing	Due to (or	as a consec	(derica (ii).									
	and and al-tra	Exar	that initiated events resulting in death) Las		c Due to (or	as a consec	quence of):							-		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical			d											
9	tificat ng phy as th	ledi		- 1		-										
XOX	leath certifica attending plant of for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								2	23d. Date of de				
O. B	the at	sicl	in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown		4□Pregnar 9□Unknow	ntattime of o	death 5	Other (sp	pecify)		-			Month Day Year		
P.0	that the de led by the a detached f		Part II. Other significa	nt conditions o	ontributing to deal	th but not res	sulting in the u	ndertvina c	ause rive	en in Part I		23e. Did	tobacco u	cco use contribute to the cause of death?		
Records,	signed of be det	d by	Den	rent. A	g		3	,	g			1 🗆	Yes 2[
COL	w requir been si should	lete										24a. Was	an	24b. Were a	utopsy findings available	
Re	rsicien: The law s certificate has t lirector, page 2 s	Completed			· · · · · ·							auto perf	psy ormed?	prior to death?	completion of cause of	
Vital	en: T tificat tor, pa	Be C	25. Was case referred	to medical						26. Place	of Death	1 ☐ Yes	2 X No one)	1 □ Yes	3 2 □ No	
<u> </u>	Physici this car al direc	To B	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 _ Inp	patient 2] ER/Outpatier	nt 3 DO	Othe	өг: 4 (Ж .)	rsing Hon	me 5 Residence 6 Other (Specify)				
0 1	ding Ph h. After th funeral		27. Manner of Death	5 🗌 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	f 2	28c. Injury Work	y at k?	2	8d. Describe	how injur	y occurred		
Sio	Attending Physicien: If death. ector: After this certific by the funeral director.	catl	2 Accident	investigation				М	_	Yes 2□	-					
Division of	or Attendations after deati	Certification:	4 Homicide	determined	289. Place of	f Injury - At h , etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factor	y, office		2	Bt. Location (City or To	Street and wn, State,	d Number or Ri	ural Route Number,	
_	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1	Certifying Ph	ysician: To the b	est of my kno	owledge, deati	h occurred	at the tin	ne, date an	id place, a	nd due to the	cause(s)	and manner as	s stated.	
	the Hi in 24 the Fu	ledical	one)		niner: On the bas and manne	r stated.	ation and/or in				in occurre	at the time,				
	To To I	Σ	29b. Signature and titl	e of certifier						e number				e signed (Mont		
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	53		30. Name and address Jesus	of person who	completed cause	of death (Iter	7 23a) (Type,	Print)	5+	E,	noth	ILVA	1111	123/0	32	
	Sta	te	31. Date filed (Month,	Day, Year)						, , ,	U) / V	1	,,,,	V -1 J	7	
	Registi		А	UG 2 3	2005	Boles o	K	South.	,							

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	Physici /Medic		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Wear Aug 21 2005 1342 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4d. County of Death
	Funeral Director		O87-26-6784 1 M 2 F 71 Yrs. Months Days Hours Min. (Month, Day, Year) 12/09/1933 New York
	h the Maryland r 28e-f ehow Lnotified at	Director	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Odenton $1 \square Yes 2 \square No$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	er death witi items 23a o rer must be	Funeral Dir	1224 Scotsmanor Court 21113 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc.
21215-0036	72 hours aft "netural", or	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 16c. NOT use retired) 16c. NOT use retired 16c. NOT use ret
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Maryland	should and Men s marke sumatic	To E	Francis William Brown, Sr. Florence Mary Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, N	0 = 0	0.00	Jacqueline K. Eastep/ Daughter 1224 Scotsmanor Court Odenton, MD 21113 20a. Method of Disposition 1
Baltir	permit. Pag Department Importent: eny injury o		21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events Due to (or as a consequence of): Due to (or as a consequence of):
68760,	icate be ex physician s the buria	licai	Due to (or as a consequence of): d
P.O. Box	that the death certif ed by the attending detached for use a	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Yes
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ai Reco	i: The law r icate has be r, page 2 sh	Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
of Vita	g Phyeician: Th er this certificate eral director, pag	n; To Be	25. Was case referred to medical examiner? 1 No Positial: 1 Inpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 No Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Injury (Month, Day Year)
Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification;	1 A Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 5 Pending investigation investigation 6 Could not be determined 6 Could not be building, etc. (Specify) 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	ledical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 293 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To th within To th comp	Me	29b. Signature and title of certifier Dapitfy 29c. License number 29d. Date signed (Month, Day, Year) 8/21/5 30. N me and address of person who conveted cause of death (Item 23a) (Type, Print) William F. Jones, mp 695 America (T-21035
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Restrar's Signature AUG 2 3 2005 32. Restrar's Signature

			For State Registrar			Marylar	nd / Depa <i>Cer</i>	rtment of F	lealth and Death		Reg. No.	005	29176
	Physicia /Medic		1. Decedent's Name (First Roy Wilson							2. Date of De Month August		Year	3. Time of Death
	Examin		4a. Facility Name (If not in 11408 Redlar		street and num	eet and number)			Location of Dea	th		nty of Death	
	Funeral Director		5. Social Security Number 236–62–5482		, 7]M 2□F	. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min		y, Year)	Cour	place (State or Foreign notry) noton DC
	and and		Usual Residence of Dece 10a. State 10b.	dent County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
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	or 28s	Director	10e. Street and Number					10f. Zip Code			10g. Citizen o		•
	sath w	ral		nds Road	12. Was Dece	fant Evar in 1	15 13 1	20657	ispania Origin? (Specify Yes or No	United	States	
0000	urs after de el', or item Terriment	by Funeral	11. Marital Status 1 Never Married 2 3 Widowed 4 D	Married	Armed Ford 1 XYes 2 If Yes, Give Year or Da	ces? 2 🗆 No	l1	Yes, specify Cubi	Specify:	no Rican, etc.)	В	lack, White,	
D-C 7	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland cartinent of Heatile and Mental Hygiene. artinent of Heatile and Mental Hygiene. artinent: If term 27 is marked other than "naturel", or items 23a or 28a-f ahow injury or other traumatic event, if a Modical Evacuit or must be invitted at injury or other traumatic event, if a Modical Evacuit or must be invitted at 29.	Completed	15. D (Specify onl Elementary/Secondary	ecedent's Edu y highest grad	cation e completed) College (1-	4or 5+)	(Give	ent's Usuaf Occup kind of work done OO NOT use retired	during most of w	orking	16b. Kind of		dustry
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מומ	id be fi ental F ked ot c ever	To Be	Roy Wilson Hoo						JoAnna 1		William Sairi	umoj	
<u> </u>	2 shou and M is mar aumati	_	19a. Informant's Name/R	elationship (Ty	pe, Print)		19b. Mailin	g Address (Street	and Number or F	lural Route Numbe	ər, City or Tow	m, State, Zip	Code)
e G	and 2 ealth m 27 i		Sandira Sue Hoo			200		Recillands Ro	The state of the s	D 20657	00-1		State -
	Pages 1 nent of H int: If ite iry or ott		20a. Method of Dispositio 1 Derial 2 Crei 4 Donation 5 0	mation 3 🗆 P	lemoval from S	tate i	-	sition (Name of natory or other places S Registry			20c. Location	-	
Бащто	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral	Service Licens			22	. Name and Addre	ss of Facility Ra	usch Funera ort Republi	al Home	206 pre	76
Records, P.O. Box 68/60,	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, on each line. Approximate Interval Between Onset and Death CADCUNSTAN The provided the condition of the conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events Due to (or as a consequence of):									Interval Between Onset and Death	
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent preginthe past 12 month 1 □ Yes 2 2 □ No 9 □ Unknown	nant ns?	d. 3c. ff yes, outc 1 □ Live bir 4 □ Pregna 9 □ Unknor	th 2 ☐ Fet int at time of wn	nancy al death 3 death 5	lEctopic pregnancy Other (specify)			1	Date of delive	Day Year
	The law requires ate has been sign page 2 should be	Completed by F	Part II. Other significant				sulting in the ur		en in Part I.	1 24a. Was autoperfo	Yes 2□No an 24	3 Prob	psy findings available impletion of cause of
VITAI	Physician: Th this certificate ral director, pag	Be	25. Was case referred to examiner?		lospital:			Ott	or	eath (Check only o			
5	Phys this aldii	tlon: To		Pending	28a. Date of		ER/Outpatien 28b. Time of Injury	of 28c. Injury at 28d. Describe how injury occurred					y)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)								n (Street and Number or Rural Route Number, Town, State)		
	To the Hospital or A within 24 hours after To the Funeral Directornology (ided in by	edical C	29a. Certifier 1 (Check only 2 ne)	Certifying Phy Medical Exami	sician: To the laner: On the ba	sis of examin	owledge, death ation and/or inv	occurred at the tile restigation, in my c	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	manner as s e, and due to	tated. o the cause(s)
	To the To the COMP	Me	29b. Signature and title o	alles	750.			Hoo	e number 3722		29d. Date sign	ned (Month,	Day, Year)
J.	D+1		30. Name and address of	person who a	ompleted cause	of death (Ite	m 23a) (Type,				uch	MS -	106517
	Sta Registi		31. Date fied (Month, Da		32/Rd 3 2005 D	gistra's Sign	ature #	Spell	JICIVE, J	ing, O	uzuy, 1	ניו מ	VOJ l

		-	For Stata Registrar	State of Ma	aryland / Do	epartment of Hopertificate of I	ealth and N Death	Mental Hyg	iene 2005	29177	
			Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	h Day Yea	3. Time of Death	
	Physicia /Medic		Margaret V.	Jozik		August	23 2005	N.4			
	Examin		4a. Facility Name (If not institution, giv		Location of Death	_					
		4	Homewood Retir				amsport		nington		
I	Funeral Director		5. Social Security Number 6. S 235–38–3603	ex	e (In yrs. last birth 87	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov . 18,	1917 9. 8	irthplace (State or Foreign Country) Onio	
	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits	
	anyla shov	5	West		Too. Oily, town					1 ☐ Yes 2 X No	
	the M	ect	Virginia Berke	ley		Martins 10f. Zip Code	sburg	11	0g. Citizen of What	Country?	
	a or	ក់					401		USA		
	leath	Funeral Director	49 Thorpe Lane	12. Was Decedent	Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race - An	nerican Indian,	
36	ges 1 and 2 should be tiled within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic evant, It e Modical Examinational be notified at	by Fun	1 □ Never Married 2 □ Married **XWidowed 4 □ Divorced	Armed Forces? 1 Yes 2720 If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerti Specify:	o Rican, etc.)	Black, Wi	white	
Maryland 21215-0036	2 hou		15. Decedent's E	ducation	16a. [Decedent's Usual Occup	ation		16b. Kind of Busines		
715	nin 72 in ni	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or :		Give kind of work done d ife. DO NOT use retired	during most of wor f)	king			
21	d with	No.	12	5		Teacher				ation	
힏	al Hy 1 othi	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, M	Maiden Sumame)		
Va	Ment Ment arkac	2		- go			Veron		edor		
Mar	2 sh and is m raum		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street					
	l and tealth sm 27 shar t	1	Paul Jozik - Son 20a, Method of Disposition			Thorpe Lan Disposition (Name of	e Marti		est Vingin 20c. Location - City	nia 25401	
Baltimore,	Pages nent of hint: if ite		1 🕅 Burial 2 □ Cremation 3 □		cemetery	crematory or other place	1				
二二	it. Pa rtmer rtant njury	ĺ	'4 ☐ Donation 5 ☐ Other (Special Signature of Fineral Service)		New ST.	Joseph Cemeter Gistorene Africa	The second secon		orth Versai	Hes,PA	
Ba	permit. Page Department of Important: if any injury or once.		21. Significate of Halland Salving			425 S. Con			lliamsport	,MD 21795	
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do no					Approximate Interval Between	
	Name to the last		shock, or heart faffure. List only Immediate Cause (Final	one cause on each li	1	alasuna				Onset and Death	
	Physician / /Medical		disease or condition resulting in death)	a Due to (or as	a consequence of	phoma				menter.	
	Examiner.										
	CALLED !	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):					
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events	c							
0,	e exe ian a urial-l	EX	resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate b physic the b	dicai		_ d							
Φ		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Date of a	lalisaar	
Вох	eath certifii attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of delivery Month Day Year		
o.	at the de by the a tached i	ysic	1 □ Yes 2 🗖 No 9 □ Unknown	9□ Unknown	, ,,,,,,	3 - 4.10. (apaciny) _			4		
Δ.	de ed		Part II. Other significant conditions	contributing to death b	out not resulting in	the underlying cause giv	en in Part J.	23e. Did tob	pacco use contribute	to the cause of death?	
rds	quires n sign Jld be	d by						1 □ Ye	as 2,1⊠No 3□	Probably 4 Dunknown	
Records,	w require s been si should b	Completed						24a. Was a	n 24b. Were	autopsy findings available	
Be	The law cate has I	шо						autops perforr	ned? death	o completion of cause of ? es 2 No	
Vital		0	25. Was case referred to medical				26. Place of Dea	ath (Check only on	77		
<u> </u>	S S	To B	examiner? 1 ☐ Yes 2	Hospital: 1 Inpatie	ent 2 ER/Out	patient 3 DOA	er: 4 Nursing H	lome 5 Reside	ence 6 Other (S)	pecify)	
J Of			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Ti	me of 28c, Injur	y at k?	28d. Describe ho	ow injury occurred		
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigation	in .			Yes 2 ☐ No				
Σ	for Attendate after death	ıtı İği	3 Suicide 6 Could not l 4 Homicide determined	289. Place of In	jury - At home, fan tc. <i>(Specify)</i>	n, street, factory, office		28f. Location (St City or Town		Rural Route Number,	
	ospits! o hours af unara! D ly filled in		- A								
	H 24 H	edical	29a. Certifier Check only One) Certifying P	miner: On the best miner: On the basis of and manner st	of examination and	death occurred at the tir for investigation, in my o	ne, date and place pinion, death occu	e, and due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
1	To the within: To the comple	M	29b. Signature and title of certifier		>	29c. Licens	e number	6 7	9d. Date signed (Mo	nth, Day, Year)	
6	(1 .		30 Name and addess of person who	completed cause of	death (Item 23a) (ype, Print	1	6010	M D)()45	
	1-1		31, Date filed (Month, Day, Year)	32 Regist	rar's Signature	in then	he I ro	4(1)	my w) a		
	Sta Registi		31, Date files (Month, Day, Year) AUG 25	2005	A.	Angel s		J			
				Marie	~ ~.	where we will be					

			1- For State of Maryland / Department of Health a Certificate of Death	7	Reg. No.	2005	29178					
I	Physici		Decedent's Name (First, Middle, Last) WILLIAM JACOBS		Date of Death Month GUST 16	, 2005	3. Time of Death 10:49 A					
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of			County of Death						
			Shady Grove Adventist Hospital Rockvi			MONTGOM						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours 383-38-7485 7. Age (In yrs. last birthday) Yrs.	Min. J	ate of Birth Month, Day, Year) an. 4, 19	4.2 9. Birthp Cour M1C	lace (State or Foreign try) :higan					
	w w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits					
	Maryl I-f sho	ţo	MD Montgomery Rockville				1 XXYes 2 ☐ No					
	or 28s	Director	10e. Street and Number 10f. Zip Code		10g. Citi	zen of What Cour						
	eath w	Funeral	310 Lisa Oaks Way 2085 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori		Ves or No.	U.S.A.						
39	urs after d	by Fun	1 Never Married 2 Married 1 Sayes 2 Na 959 If Yes, specify Cuban, Mexican		n, etc.)	Black, White, Specify: Bla	etc.					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel; or Items 23a or 28a-f show among young other traumatic event, the Medical Exam and missible modified at another.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-5 or 5+)	st of working	16b. Ki	nd of Business/Ind	·					
Q 2	filed w Hygie other t		3 yrs Manager 17. Father's Name (First, Middle, Last) 18. Mothe	ner's Name (Firs	st, Middle, Maiden	I.B.M.						
/lan	should be nd Mental marked c	To Be	Ulysses Jacobs	Claud	ia Cann	on						
Man	d 2 sho		19a. Informant's Name/Relationship (Type, Print) Mary E. Jacobs (Wife) 19b. Mailing Address (Street and Number 310 Lisa Oaks W									
<u>6</u>	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	_	cation - City or To						
<u>E</u>	Pages ment of H ent: if ite		'4 Donation 5 Other (Specify)									
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Sign fure of Funeral Service Lice see 22. Name and Address of Facility 246 N. Wash.	. St.,	Rockvi							
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
	Fnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death) a. Accute Mocardian Infart	ction		t	ninures					
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute Mountain Triforchia Triforchia Due to (or as a consequence of): b. HeroSciential Coron And Articles Due to (or as a consequence of):									
	led sit	ulner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		0							
o	cate be executed obly sician and the burial-transit	Examiner	that initiated events ' c. resulting in death) Last Due to (or as a consequence of):									
8760,	ate be physicia the bur	dical	d.			-						
Box 6	eath certific attending p I for use as 1	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ery					
o.	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Me	Company Comp	2 No 4 Pregnant at time of death 5 Other (specify)								
ds, P	uires that signed b d be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco u	pacco use contribute to the cause of death?							
Vital Records,	aw requir s been si 2 should	Completed			24a. Was an	24b. Were auto	psy findings available					
l Re		Com		1	autopsy performed? I ☐ Yes 2 ☐ No	death?	npletion of cause of 2 No					
Vita	rysicien: Th ris certificate director, pag	Be	examiner?	ce of Death (Ch								
o	- E	n; To	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at		5 Residence Describe how injur		/)					
sion	ittending f death. ctor: After y the funer	catlo	2 Accident investigation M 1 Yes 2	□No								
Division	l or Attendation after deation. Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street an City or Town, State		l Route Number,					
	To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date are and manner stated.	and place, and death occurred at	due to the cause(s) the time, date and	and manner as si place, and due to	ated. the cause(s)					
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier 29c. License number		29d. Dat	e signed (Month,	Day, Year)					
1	12		Grandon New Dood 5802	5	Aua	ust 1	5 2005					
	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan M. Wenk, M.D. 9901 Medical Center Drive;	Rockyi]]e.MD	20950						
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 3 2005 32. Registrar's Signature	TOOK T	LIII	20700						

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month AU9 **Physician** JEFFERSON NIADMA TATILDA 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner All Saint FREDERICR FREDERICK 8. Date of Birth (Month, Day, Year) DEC. 25, 1915 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. Days Hours 1 ☐ M 2 🗹 F 214-16-1585 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and them 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examinating in that he mailthed at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD. FREDERICR FREDERICK by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SAINT U.S. A. 21701 192 WEST 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2☑No Specify: BLACK Maryland 21215-0036 Specify 3 ☑ Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ST. JUHNS College (1-4or 5+) Elementary/Secondary (0-12) 1274 COOK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FLETCHER BERTHA WILLIAM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) HOLLENBERRY RD. 6948 SYKESVILLE MO. 21784 Gassaway (dau) Helen Ivene Baltimore, Date 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State semetery, crematory Aug 22, 2005 FREDERICK, 1 Burial 2 □ Cremation 3 □ Removal from State MO. Department (Important: If any injury or * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FUNERAL HUME 21. Signature of Funeral Service Licensee 21701 FREDERICK MD X 30UTH ST complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Colon Month Pnysician Metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year for Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation s after dea... 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D43091 8-22-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOLL House Ave Laidi Sace 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 2 3 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 10:45 AM CLARENCE W. JONES August 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 220-01-6129 3/30/1922 83 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10b. Count 10a. State 10c. City, Town or Location 1 show 10d. Inside City Limits traumatic event, the Medical Exerting must be notified at MD Harford Director Havre de Grace 1 ☐ Yes Mo 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 3537 Green Spring Road 21078 itams 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Tyes 2 No If Yes, Give Year or Dates: 1944–46 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XÑo Specify: White by 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Civil Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental H is markad of Philip Augustus Jones Mary Rebecca Townslev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Jones/Wife itam 27 3537 Green Spring Road, Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Evans Eagle Crematory 8/29/2005 *4 ☐ Donation 5 ☐ Other (Specify) Leola, PA 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA 17314 Part I fanter the disease, or complications that coused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Pnysician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial Box 68760. Physician/Medical esn esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No the 9 Unknown à signed t Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page certificate 3 No 212 No 1 Yes 1 🗌 Yes Division of Vital Hospital or Attanding Physician: director. Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Injury Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation after death in 24 hour.

tha Funaral Dirac. 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 Fo tha 29b. Signature and title of 30. Name and address of person who 31. Date filed (Month, Day, Year) State SEP 0 7 2005 Registrar

			1 - State Registrar	State of Man		artment of F		Mental Hyg	iene .g. N2005	29181
	Physici		Decedent's Name (First, Middle, Las Vivian Ward Kno					2. Date of Deat Aug. 19	h	3. Time of Death 8:52 P M
	/Medic Examir		4a. Facility Name (If not institution, give Calvert Memoria.			4b. City, Town, o	r Location of Dea Frederi	ck	4c. County of Death	1
	Funeral Director		578-03-4809	T	In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		918 918 Vir	place (State or Foreign Intry) ginia
	e Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Calvert	1	Oc. City, Town or Lo	nd				10d. Inside City Limits 1 ☐ Yes 2√ No
	a or 2	Dire	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	intry?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If itam 27 is merkad othar than "natural", or itams 23a or 28a-1 show or othar traumatic evant, the Medical Exercity or unit be neithed at	by Funeral Director	1820 Valley Lane 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	er in U.S. 13.	20689 Was Decedent of H If Yes, specify Cuba 1□Yes 25th No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
21215-0036	hin 72 hours s. an "natural", Medical Ex.	Completed b	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grav Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	orking	16b. Kind of Business/I	
21	ed witi ygjene yar tha	Com	12		Home	maker			Own Home	
Maryland	ould be fill Mental H arkad oth	To Be	17. Father's Name (First, Middle, Last) Harry F. Ward				Reber	ame (First, Middle, M tia Carri	.co	
2	and 2 shu ealth and m 27 is m		19a. Informant's Name/Relationship (7 Bill Knott (Son		1820	Valley		nderland,	, City or Town, State, Z Md 20689	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trae once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			matory or other plac	1	1	20c. Location - City or 1 Cheltenha	
Balt	permit. Departr Imports any inje		21. Signature of Puneral Service-Licen Danie 11e Wan		2	2. Name and Addre	ss of Facility LE	e Funeral	Home Calv	ert P.A.
}	Physician /Medical		23a. art. Enter the disease, or companies, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	olications that caused the one cause on each line. a	CVA	ter the mode of dyin	ng, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Due to (or as a c	tho consequence of): Seizun	DV7	isosder			
8760,	cate be executed physician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a c	consequence of):					
P.O. Box 68	death certiff e attending ed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Nio 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tiri 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of delin Month	very Day Year
	w requires that been signed by should be deta	b	Part II. Other significant conditions of	ontributing to death but r	not resulting in the u	inderlying cause giv	en in Part I.		pacco use contribute to	/
I Records,	The la ate has page 2	Completed						24a. Was a autops perform 1 □ Yes 2	v prior to c	opsy findings available ompletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only on		
of	ing Phys n. After this funeral dii	tion; To	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpatie 28b. Time of (ear) Injury	of 28c. Injur Wor	y at k? Yes 2 \sum No		once 6 Other (Spec ow injury occurred	ify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, st (Specify)			28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
	To tha Hospital within 24 hours a To tha Funaral completely filled	Medical (29a. Certifier (Check only one) Certifying Physics (Check only one) Medical Example (Check only one)	ysician: To the best of r liner: On the basis of ex and manner state	camination and/or in	h occurred at the tir evestigation, in my o	ne, date and plac pinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier S WW	MD		29c. Licens	s 029	0	9d. Date signed (Month	- 05
_	5		30. Name and address of person who do	completed cause of deal		Print) OSP F	RD.	Prince	Frederica	MD 20678
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrates	Signature	Societies				

			1 - For State Registrar	State of Maryla		artment of F		Mental H	ygiene Reg. N2 0 0	5 29182
-	Dhyaiai	00	1. Decedent's Name (First, Middle, L.	ast)			-	2. Date of D	eath	3. Time of Death
	Physici /Medi		Carl Heinrich	Lavendt				Aug.	15, 200	7ear 5 1:30 p M
1	Examir	ıer	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of	
			Calvert Memor 5. Social Security Number 6.	ial Hospita	1 s. last birthday)	Prince If Under 1 Year	Freder		Ca	alvert
	Funeral Director		,	1 M 2 □ F 7. Age (in yr	Ven	Months Days	Hours Min.	(Month, D	irth Day, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	/5)			5/6/	1930	Germany
	death with the Maryland ms 23a or 28a-f show I must be notified at		10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limits
	r 28a-f s	cto	MD Cai	vert		Owi	ngs			1 ∑ Yes 2 □ No
	다 55 M	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	- a		ek Lane		207	36		US.	A
		Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or N o Rican, etc.)	o- 14. Race - Black.	American Indian, White, etc.
36	hours aftar ural', or its	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give ↑ Year or Dates:		1□Yes 2√□No	Specify:		Specify:	
5-0036			15. Decedent's E	ducation	16a, Dece	dent's Usual Occup	ation		16b. Kind of Busin	White
215	nin 72 in "net	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking	TOD. KING OF BUSI	ness/industry
2121	ad within	Ĕ	12	College (1-4or 5+)		Estima	tor		Con	struction
b	≝££ E	Bec	17. Father's Name (First, Middle, Las)		20011110		ne (First, Middle	e, Maiden Sumame)	
<u>a</u>	Manta Manta arked	2	Karl Lavendt				Marga	rethe	Schmidt	
Maryland	s 1 and 2 should be if Haaith and Mantal I tem 27 is marked o other treumetic svs		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Numb	per, City or Town, St	ate, Zip Code)
	1 and 1 Haaith sm 27		Christa Lavend				reek La	ne, Ow	ings, M	D 20736
altimore,			20a. Method of Disposition 1 \$\overline{\pi}\$ Burial 2 ☐ Cremation 3 [Removal from State		natory or other place		Date	20c. Location - Ci	ty or Town, State
Ë	. Pag Imeni tant: jury o		* 4 ☐Donation 5 ☐ Other (Speci	y) So	o. Memo	orial Go	dns 8/1	8/2005	Dunkir	c, MD
Bai	parmit. Page Dapartment o Important: If any injury or ance.		21. Signature of Funeral Service Lice	nsee	22	. Name and Addres	ss of Facility R	avmond		H., P.A.
	40 = 4 G		23a. Part1. Enter the disease, or con	7	P(Box 4	30. Dun	kirk.	MD 20754	
8760,	Physician and burier transit in a burier transit in the burier tra	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.)	quence of):	T H Y				Interval Between Onset and Death
P.O. Box 68	Tha law raquiras that tha death cartifical ate has baan signed by tha attanding phypage 2 should ba detached for usa as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	
Vital Records, F	w raquiras tha baan signed shouid ba dei	Completed by P	Part II. Other significant conditions		sulting in the un	derlying cause give	en in Part I.			te to the cause of death?
တ္တ	aw raqu Is baan 2 shouk	plet						24a. Was	an 24b. Wer	re autopsy findings available to completion of cause of
ž	Tha I	E			,,,,			auto	omeg? dea	th?
ita	riffica	Bec	25. Was case referred to medical				26. Place of Dea			Yes 2□No
f V	Physician: r this cartifica rai diractor, i	2	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatient	3 DOA Othe	AC .		dence 6 ☐Other ((Specify)
n of	ng Pt tar th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			how injury occurred	
Ö	Attending ir daath. sctor: Aftai by tha funa	atle	2 Accident investigation	n	qury		res 2 □No			
Division	s aftar de s aftar de al Direct	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre	et, factory, office		28f. Location (. City or Tou	Street and Number own, State)	or Rural Route Number,
	To the Hospital or Attending Physician: Tha favinin 24 hours aftar daath. To the Funeral Director: Aftar this cardificate has complately filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	2001		29c. License	number		29d. Date signed (A	fonth, Day, Year)
			Slynis C	1 Moude	140		5233		8/15/	05
	ا من		30. Name and address of person who						PRINCE	FREOERICK.
	15		GLYNIS A M	0004,40	110 HO	SPITTAL C	DE, SUITE	5310	MO	FREDERICK, 20678
Š.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature #	Smile				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Lewner 2005 1:40 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1114 Boucher Avenue Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**№** M 2□ F 217-18-0590 15, Director 86 November 1918 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Annapolis XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1114 Boucher Avenue 21403 Items 23a United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 200 Married 1xXYes 2 □ No ŏ Baltimore, Maryland 21215-0036 1 Yes 2000 Yo Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: 1942-1946 'neturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Budget Analyst U.S. Government permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygie Important: If item 27 Is marked other1 eny injury or other traumatic event. Ib 17 Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Sam Lewnes Cecilia Mandris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Lewnes/ wife 1114 Boucher Avenue Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 8-25-05 Annapolis, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cereno vascu Proysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician The law requires that the death certificate be Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 21 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 5 sidence 6 Other (Specify) 2 3□ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ol or Attending F After 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 🗌 No investigation Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature pleted cause of death (Item 23a) (Typ 2-1 d 31. Date filed (Month, Day, Year) 32/Registrar's Signature State Registrar 2005

AEM # 05-05639 Carrol Sue Lesile

Physician

Funeral

Director

"natural", or items 23s or 28s-f show adical Examiner must be notified at

Hygiene. other than "natura ent, the Medical E

other

Pages 1 and 2 should be fi ment of Heelth and Mental H sant: If Item 27 le markad otl jury or other traumatic ever

permit. Page Department o Important: If any Injury or once.

Physician

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Examiner

Be Completed by Physician/Medical

Certification: To

Medical

the Maryland

with

filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Carol Sue Leslie August 20,2005 2:48pm M 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1350 Walnut Road Port Republic Calvert 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 26 1 Birthplace (State or Foreign Country) Days Months Hours Min. 1 M 2 KF 48 Yrs. 216-70-8268 1957 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Calvert Director Port Republic 1 Tyes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1330 Walnut Road 20676 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 health care nurses aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William E. Lent Shirley A. Waid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5710 Long Beach Dr. St. Leonard, MD 20685 19a. Informant's Name/Relationship (Type, Print) Randy Lent- brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 23 2005

Metropolitan Funeral SErviceAlexandria Virginia 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee Rd. Port Republic MD 20676 1405Broomes Is. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asphyxia Due to (or as a consequence of). Aspiration of foreign object Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time ol death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 1 No. 2 No 25. Was case referred to medical 26. Place of Death (Check only one, 1 Yes 2 □ No

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 physicien be detached for use as the hes this certificate funeral After death. nours after death.

neral Director: A To the Hospital within 24 hours a To the Funeral C Hospital

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 - Homicide 1 So wather Rd, Part Republic Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 820 2005 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28b. Time of 1142

28c. Injury at Work? P M 1 Yes 2 Mo

29c. License number

OCME

Other: 4 Nursing Home 5 Residence 6 QOther (Specify) SCENE 28d. Describe how injury occurred

subject chaked on hot dog 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rd, Part Republis, 1350 Walling Rd, Part Republis,

August 21,2005

29b. Signature and title of certifier Josh

29d. Date signed (Month, Day, Year)

Joe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenberg Tasha Z M.0 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

2. Registras Signature AUG 2 3 2005 >

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Aug. 18 2005 Priscilla Siner Lankenau 7:32 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons
If Under 1 Year If Under 24 Hrs. 506 Runabout Loop Calvert 9. Birthplace (State or Foreign Philadelphia 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 74 Director 170-24-2687 Yrs. 7-11-1931 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show othar traumatic event, the Madical Examinar must be notified at Director MD Calvert Solomons 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 Runabout Loop 20688 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation

Other kind of work done during most of working Completed 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Association Executive Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Raymond Kingsley Siner Lillian Wallace Fahr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6717 Capstan Dr., Annandale VA, 22003 Kimberly Siner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lee Crematory 8-20-05 Clinton, MD 21. Sign ture Funeral Service Licen 22. Name and Address of Facility Lee Funeral Home Calvert P.A. Dan volle Marke 8125 Southern Maryland Blvd. Owings MD, 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** v terioscle disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner use as the burial-transit certificate be executed Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mop ó Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examine 1 Ves Other: 26 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Prisidence 6 Other (Specify) this 27. Mann of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pr 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address person who completed cause of eath (Item 23a) (Type, Print) Kaymon ble 0 32. Registre s Signature 31. Date filed (Month, Day, Year) State 2005 ▶ Registrar

na S. Lan	ie	1 - State Amend Ite	State of Mar ems 28a,b per	ryland / l	Certifica	17/05 te/05	lealth a dhb Death	and M	lental Hy	/giene Reg. No.	200	5 29186
Physicia	an	Decedent's Name (First, Middle,	Last)						2. Date of D Month	Day		
/Medic	al	KEISHA S. LANE 4a. Facility Name (If not institution, s	nive street and number)		4h Cib	Town o	Location of	of Dooth	August		200 County of D	
Examin	ier	Baltimore Washin		Cente		en Bu		Ji Death		1.	ne Aru	
Funeral		Social Security Number 6	. Sex 7. Age	(In yrs. last bir	thday) If Unde	er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi			Birthplace (State or Foreign Country)
Director		235-37-0443 Usual Residence of Decedent	1□M 2X)F 1	.5	Yrs.		110013		8. Date of Bi Month, D MARCH 20), 199	O WE	ST VIRGINIA
land ow		10a. State 10b. County		10c. City, Tow	n or Location						-	10d. Inside City Limits
a-feh	tor	MD WASH	INGTON		HAGERS	STOWN						XX Yes 2 No
ith the	Director	10e. Street and Number			10f. Z	ip Code				10g. Citiz	zen of What	Country?
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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar must be inclined at once.	by Funerai	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes, 2XXNo If Yes, Give Year or Dates:		13. Was Dece		ispanic Ori in, Mexicar Specify:	gin? (Sp 1, Puerto	ecify Yes or N Rican, etc.)			merican Indian, /hite, etc. BLACK
72 ho	eted	15. Decedent's (Specify only highest)	Education	16a.	Decedent's Use	ual Occup	ation	t of work	ing	16b. Kir	nd of Busine	ss/Industry
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nould be fill d Mental H narked ott natic even	To Be	17. Father's Name (First, Middle, La RONALD L. PU	LLER	101		(2)	Į	LUCRI	ETIA M.	LAN	E	
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s 1 ar of Hea item other	- 5	20a. Method of Disposition		20b. Place of	Disposition (Na	me of	1		oate T 29,			or Town, State
Page nent c ant: If ury or		1 XX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			PE CEMETE		1	2005	1 29,	MART:	INSBURG	, WV
permit. Departr Importa any inj.		21. Signature of Funeral Service Lic	Bian)	22. Name a BROWN	FUNER	AL HOM	ŽE P. RTINS	O. BOX 8 BURG, WV	321 32 7 25402	27 W. K	ING ST.,
Physician /Medical Examiner	er	23a. Part1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying	a. Questo (or as a Due to (or a) Due to	sho+	Wound	do	7 (lu lu	2S+	irrest,		Approximate Interval Between Onset and Death
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eath certifi ettending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ⊟Ectopic p 5 □ Other (s					2	3d. Date of o	delivery Day Year
quires thet in signed build be deta	Ď	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying	cause give	en in Part I.		23e. Did 1		-	to the cause of death? Probably 4 □Unknown
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Phys r this sral dii	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient		ime of		4 🗆 140		ne 5 🗆 Resi 28d. Describe			pecify)
nding Pł ith. : After the funeral	tio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day)	(ear) ir	ime of 3:01	28c. Injury Work 1 ☐ \	:?` ∕es 2 ∑ ⊈	1	Dogo	rsoc	Q Sh	ot
P S S S	Certification:	3 Suicide 6 Could not determine	be 28e. Place of Injury building, etc.	At home, fair	rm, street, factor			1				Rural Route Number, COUNT CULL SEVENTI, MD
Mospital 24 hours a Funerel I etely filled	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of earniner state	xamination and	, death occurred Vor investigation	at the tim	e, date and pinion, deat	d place. a	and due to the	cause(s) a	and manner	as stated
within 2 To the comple	Me	29b. Signature and fille of certifier	n.		29	c. License	number			29d. Date	signed (Mo	nth, Day, Year)
		30 Name and address of	1 /M	th (Itom 00-)		O.C.M	.E.			Augu	st 18	2005
2		30. Name and address of person wh	cause of dea	th (Item 23a) (111 I	1ype, Print) Penn Str	eet.	Balt	imor	e, Marv	y la nd	21201	L
		31. Date filed (Month, Day, Year)	32. Registrar's									

			1 - For State Ragistrar	State of Marylar	nd / Depa <i>Cei</i>	artment of F	lealth and N Death	Mental Hygid	ene200	5 29187
ı	Physici		Decedent's Name (First, Middle, Last Jean W.	Mayhew	-			2. Date of Death Month August	Day Ye 20, 200	3. Time of Death 5 1:40 a M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of I	
			8400 Adelphi Road	l		Hyatts			Prince	e George's
	Funeral Director		5. Social Security Number 6. S 213-54-6459	9x 7. Age (In yrs. □ M 2X F 80	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 13,	rear)	Birthplace (State or Foreign Country) New York
	ס		Usual Residence of Decedent					Journ 15,	1525	NEW TOTK
	arylar show det	<u>.</u>	10a. State 10b. County	10c. Ci	ty, Town or Lo	ecation				10d. Inside City Limits
	28a-f	Director	Maryland Prince C	George's	Hya	ttsville 10f.Zip Code		140	000	1 ☐ Yes 2X No
	with with Liberra		8400 Adelphi Roa	bo		20783		100	g. Citizen of Wha	SA
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U		Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-		American Indian,
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygisne. Is marked other then "natural", or items 23a or 28a-f show aumatic event, the Medical Exarthmetinatic event, the Medical Exarthmetic and	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	-	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: V	White, etc. White
Maryland 21215-0036	72 ho	Completed	15. Decedent's Ec			dent's Usual Occup- kind of work done of		ring 16	6b. Kind of Busin	ess/Industry
2	ithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	,,,,g		
2	iled w Tygier Thar tl		17. Father's Name (First, Middle, Last)	2	Ног	nemaker	18 Mother's Nam	e (First, Middle, Ma	Own Hon	ne
and	d be fantal h	o Be	Joseph F. Weing	arden. Jr.			Julia		uden Surrame)	
JZ.	shouth nd Me mark	2	19a. Informant's Name/Relationship (1		19b. Mailir	ng Address (Street		al Route Number, (City or Town, Sta	te, Zip Code)
	and 2 salth a n 27 is		Anthony G. Mayh		8400	Adelphi	Road, Hya	attsville	, Marvla	and 20783
Baltimore,	Pages 1 a		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, crer	sition (Name of matory or other place even Cemete	a) Aug	Date 24,	c. Location - City	y or Town, State
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any in marked any in marked any in marked and in marked and in marked and in marked and in marked and in marked and in marked		21. Signature of Funeral Service Licen				s of Facility.	Funeral	Home Inc	oring,Maryland c ing, MD 20901
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	Pnysician /Medical	8	Immediate Cause (Final disease or condition resulting in death)	a. Ischemic Ca		opathy				Onset and Death 3 Weeks
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Diabetes						50 Years
20,	oe execian a		resulting in death) Last	Due to (or as a conseq	uence of):					
8760	icate be executed physician and s the burial-transit	dical		d.						
ox e	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				23d. Date of	delivery
.O.	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
ر. م	res that igned b	by Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribut	te to the cause of death?
rds	w require been sig should b							1 🗆 Yes	2 ≅ No 3[Probably 4 Unknown
Records,	e law re has bee je 2 sho	Completed						24a. Was an autopsy	24b. Were	autopsy findings available
		Com						performe	d? deat	to completion of cause of h? Yes 2 \sum No
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	d is	To	1 ☐ Yes 2 🔀 No 27. Manner of Death		ER/Outpatien	t 3 DOA Othe	4 Nursing Ho	me 5 🖾 Residend		Specify)
OU	ding h. After funer	tlon	1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	at (? Yes 2 □ No	28d. Describe how	injury occurred	
Division of	Attan r deat sctor: by the	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, str			28f. Location (Stree	et and Number o	r Rural Route Number,
	s afte	Cert	4 Homicide	building, etc. (Specif	(Y)		T.	City or Town, S	State)	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Madical Examone) 1 Madical Exam	ysician: To the best of my kno liner: On the basis of examina and manner stated.	owledge, death tion and/or inv	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manne a and place, and	r as stated. due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	1		29c. License			. Date signed (M	
	12		* Auchal	Krome Hel	rand	D2	6287	At	ugust 22	., 2005
			30. Name and address of person who michael J. Berar	d, M.D. 7305	Baltimo		#107, Co	ollege Par	rk, MD 2	0740
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 2 3 21	32 Registrar's Signa	App.	entil				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Reg. No 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8 2005 1:37 A^M Edwin George Murray /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Worcester Atlantic General Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. 6/2/1955 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1**X**M 2□ F PÃ 50 Director 175-46-9210 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 le marked other than "neturel", or Items 23s or 28e-f show other treumetic event, the Medical Evaluand russi for inclified at 1 Yes 2X No Director Sussex Selbyville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number RD #1 Box 127 19975 USA by Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □Yes 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Importent: If item 27 le marked other than College (1-4or 5+) Elementary/Secondary (0-12) Boat Repair 12 Mechanic 08/33/ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence G. Murray Geraldine Wonderly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RD #1 144c, Selbyville, DE 19975 Geraldine Murray 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State any injury or 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 8/23/2005 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part1. Enter he disease, or complications that cause shock, or head ailure. List only one cause on each li Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death one cause on each line Immediate Cause (Final disease or condition resulting in death) meringi Physician 1 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 2 →No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 4 NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 1 Tyes -21 28a. Date of Injury (Month, Day Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Sunerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

05-05696 Ronald Murphy **RJD**

Funeral

Director

or 28a-f show

the

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Hygiene. other then "neturet", or items 23a or 28a-f shov ent, tra Modical Examinar must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if Itsm 27 is marked oth any liqury or other traumatic event ang.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 1 per meo 9847 9-7-05 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death Decedent's Name (First, Middle, Last)
Reneld renels Murphy 2 Date of Death 3. Time of Death Ronald Francis Murphy Physician Mugust 23, 2005 0535 А. м /Medical 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton Prince Georges 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 215-06-5279 Birthplace (State or Foreign Country) 1∯M 2□F Yrs Oct.3,1967 Washington D.C Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MARYLAND CHARLES HUGHESVILLE 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5829 BRANDYWINE ROAD U.S.A. Funerai 20637 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X X No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 為OXNo Specify Specify: WHITE 3 ☐ Widowed 4 ☑ Vivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TILE SETTER JOHN KING TILE CO. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) FRANCIS ADRIAN MURPHY GRACE ANN QUADE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5829 BRANDYWINE RD., HUGHESVILLE, MD 20637 GRACE A. MURPHY-MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE PARK CREMATORY 8-25-05 RIVERDALE, MD 21. Signature of Fureral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a COMPULATIONS Of CHROME ALLOHOUSE Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No autopsy performed? 12 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 □ No 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred

Physician /Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit nding physicien and Box 68760. Division of Vital Records, P.O. Signed should i certificate : After this certification of the thick the th within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death To the Hospital

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 Natural Injury 1 Tyes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the dates(s) and nanner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) August 24, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 21201 , MO ANA RUB10

State Registrar

Medical

31. Date filed (Month, Day, Year)

32 7 2005



State of Maryland / Department of Health and Mental Hygien 9 0 0 5 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Edwin Lloyd 2005 Meeds August 10:15 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1713 Perseus Road Church Creek Dorchester If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec. 11 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**⊠**M 2□F Yrs. Director 516-20-9228 77 Montana 1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No MD Dorchester Church Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 1713 Perseus Road 21622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Styles 2 □ No If Yes, Give Year or Dates: 1946–47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont I tem 27 is marked other than "neturel; or ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) attorney law 11 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Allen Meeds Mary Ethel Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Meeds wife P. O. Box 82, Church Creek, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If ite eny injury or of once. 1

Burial 2 □ Cremation 3 □ Removal from State ' 4 Donation 5 Dother (Specify) Arlington National Cem. 9/15/05 Arlington, VA 21. Signatur of Funeral Service ticensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. PartiVenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCER **Physician** UNG SIX MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or). The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by signe 1 be 1

Yes 2

No 3

Probably 4

Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No performed? 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. KE GIBSON 1650 BRUKANA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Linnie Sue Renshaw Mowbray 2100M 19 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorio EASTON DITA If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1957 **Funeral** Days Months Hours 1 □ M 2 □ € 220-68-8267 Director 47 Yrs. Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov or other traumatic avant, It's Madical Examinar must be notified at Directo 1 ☐ Yes 2 ☐ 100 Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1034 Hudson Rd. 21613 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married $\mathsf{MOWDRAY}_{\mathsf{SU}}$ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Renshaw, Sr. <u>Betty Lee Moore</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health an permit. Pages 1 and 2: Department of Health ar Important: If itam 27 Is any injury or other trau once. Michael J. Mowbray, Sr./Spouse 1034 Hudson Rd., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 2 Cremation 3 Removal from State ^ 4 □Donation 5 □ Other (Specify) Spedden-SewardCemetery 8/24/2005 | Cambridge, MD 21. Signature of Funeral Sofwice Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home 308 High St., Cambridge, MD 23a Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CEREBRAI EDEMA /Medical Due to (or as a consequence of): **Examiner** BRAIN METASTAS18 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed CUNG CANCER that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 ☐ Yes To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059487 dutrotses 30. Name and adors ss of person who completed cause of death (Item 23a) (Type, Print) 219 S. Washington St., Easton, MD 21601 Dr. John Botsis,

Registra

31. Date filed (Month, Day, Year)

2005 Registrar's Signature

		1	For State Registrar	State of I	Maryland		artment <i>tificate</i>			and Me		giene Reg. No	200	5	291	92
	Bhusiala		1. Decedent's Name (First, Middle, La							2	2. Date of De Month	eath Da	y Y	ear	3. Time of	Death
	Physicia /Medic	al -	Connie Mary M						1		August	1		D 4b	6:00	AM M
	Examin	C.	4a. Facility Name <i>(If not institution, gi</i> William Hill Heal					ston	Location o	or Death		40	County of Talb			
	Funeral				Age (In yrs. la:	st birthday)	If Under	1 Year	If Under		8. Date of Bi	rth	0	Birthpl	ace (State of	r Foreign
	Director		147-14-2715	1□M 2 ∏ F	79	Yrs.	Months	Days	Hours	Min.	(Month, D	,192	6 P	coun	ylvan:	ia
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10	0d. Inside Cit	y Limits
	Maryli fed a	Į.	Maryland Dorchest	er	Camb	ridge									1 🕅 Yes	2 🗌 No
1	death with the Maryland ms 23a or 28a-f show rmust be notified at	0	10e. Street and Number				10f. Zip	Code				10g. Cit	tizen of Wha	t Coun	try?	
7	23a c 23a c ust bs	ai	2607 Lance Drive					216					USA			
ク	er dez Items Der m	Funeral	11. Marital Status	12. Was Decede Armed Force 1 ☐ Yes 2	es?	13.	Was Deced f Yes, spec	lent of History of Cubar	spanic Ori n, Mexicar	igin? (Spec 1, Puerto Ri	ify Yes or Nican, etc.)	0-	14. Race - Black, 1			
39	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 💥 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	2⊠ No	Specify:				Specify:	W	hite	
ဝို	72 hou	eted	15. Decedent's E (Specify only highest g	ducation ade completed)		16a. Deced	kind of wor	rk done a	urina mos	t of working	g .	16b. K	(ind of Busin	ess/Ind	lustry	
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, D	filed v Hygie ther t	ပ္	9 17. Father's Name (First, Middle, Las	t)		Meat	Cull	EI	18. Mothe	er's Name ((First, Middle	1	t Pac	KTIIE	5	
an	lid be lental ked o	To Be	Paul Patula						Mar	cia Ur	rciull	0				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examinat must be notified all once.	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rural	Route Numb	er, City	or Town, Sta	te, Zip	Code)	
Σ.	and 2 ealth m 27 i) <u>)</u> .	Linda Oliver/Dau	ghter	20h Ble					oad, V	Woolfo				Ctata	
Baltimore,	iges 1 or of H or ot	1	20a. Method of Disposition 1 Burial 2 Cremation 3	X Removal from Sta	ate	nce of Dispo metery, crer			1				ocation - Cit			
Ē	artmer artmer ortent injury	- 4	' 4 ☐ Donation 5 ☑ Other (Spec 21. Sign tup of Fineral Service Act		nt Holy	22	. Name an	d Addres	s of Facilit	3/23/2 tv					Jerse	У
Ba	Depril Impo		Decuerd	40	elle	Ze P.	11er	Fune	ral 1	Home, East	106 N New Ma	lain erket	Stree	t 216	31	
	100		232. Parth. Enter the disease, or conspose, spock, or heart failure. List only	mplications that cau	sed the death.	Do not ent	er the mod	e of dying	, such as	cardiac or	respiratory	arrest,	, 1111		Approximate Interval Bety	veen
	Physician		Immediate Cause (Final disease or condition	Fr	onta	1 m	eni	na	com	a					Onset and D	Death 2
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):		0								
		Pe	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseque	ence of):								-		
	cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease of injury that initiated events	c												
8760,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of):										
687	physic physic s the b	dicai		d												
Box (death certific e attending p d for use as	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnan		Teanin n						23d. Date of	f delive	гу	
		ਹ	in the past 12 months? 1 ☐ Yes 2 ☐No		nt at time of de		∃Ectopic pr ∃ Other (sp						Month		Day Y	'ear
P.0	by ac	Physi	9 Unknown Part II. Other significent conditions	contributing to deal	th but not resul	lting in the u	nderlyina c	ausa dive	n in Part I	1	23e, Did	tobacco	use contribu	ute to th	e cause of de	eath?
ds,	se us	d by	Diabetes				,				1 🗆	Yes 2	10 0 3	□ Prob	ably 4 □U	Inknown
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/ital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					1		e of Death	(Check only					
of \	this al dii	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp 28a. Date of		R/Outpatier		Othe 28c. Injury	4/24/1		e 5 ☐ Res 8d. Describe			(Specify	')	
no	ding h. After fune	tlon	1 Natural 5 Pending 2 Accident investigat	(Month,	Day Year)	Injury	M	Work	(? Yes 2□		00. 2000120	11017 11130	ily occurred			
Division	l or Attending after death. Director: After I in by the fune	ertification;	3 Suicide 6 Could not	be 28e. Place of	f Injury - At hor , etc. (Specify)	me, farm, sti	reet, factory	y, office		28	8f. Location City or To	(Street al	nd Number	or Rura	Route Numi	ber,
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	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	edicai		Physician: To the beaminer: On the bas and manne	is of examinati)
	To the within 2. To the Complet	Med	29b. Signature and title of certifier	2 000	statou.		290	c. License	number			29d. Da	ate signed (I	yonth, i	Day, Year)	
	F > F 0		Ill ha	ller	mo			D=	35 Z	84		8	3/191	OJ		
			30. Name and address of person wh		of death (Item	23a) (Type,	S W	last	ing	tra	Ste	asi	ton.	no	Z/60	0/
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 3 20	005 Rec	gistrar's Signat	ure	والمحاصة									

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 29193 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 21, 2005 Year **Physician** Emma Louise McGaughey 12:45 P M /Medica! 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. 87 April 19 1918 Director Maryland 213-22-0323 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Intent 17 to marked other than "natural", or Items 23e or 28e-f show mrit. If item 27 be marked other than "natural", or hitems it was not the resulting at the Medical Examination to the resulting at the medical Examination of the resulting at the Medical Examination of the resulting at the Medical Examination of the resulting at the Medical Examination of 10a. State 10c. City, Town or Location 10d. Inside City Limits Prince Frederick Calvert Maryland 1 ☐ Yes 🏖 No Director 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20678 250 Chesapeake Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify: If Yes, Give Year or Dates: þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lillian C. Dove Howard A. Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).
P.O. Box 871 250 Chesapeake Ave. Prince Frederick MD 20678 Wanda Nagers - daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Broomes Island Maryland Broomes Island Cemetery August 25 2005 permit. Pag Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Hone 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Manie /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Non-Small Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient Certification: To 2 No 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WD 0603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE VEEB 00 31. Date filed (Month, Day, Year, 32. Registr

State

Registrar

2005

AUG

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year /Medical Santa Sara Otilia Zappa Mc Cullagh 21, 2005 5:20 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince If Under 1 Year <u>Calvert Memorial Hospital</u> Frederick

If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Calvert 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🛱 F Director 579-42-9127 83 11/1/1921 Argentina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner Investment in Item 2006. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1√2 Yes 2 □ No MD Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85 Hospital Road 20678 Argentina Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: 3 ₩ Widowed 4 Divorced White Argentinean 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Atilio Julio Zappa Rosa Gaeta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Alley/Daughter
20a. Method of Disposition 3845 South Shore Dr., Pt. Republic, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 8/26/05 Suitland, MD 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Raymond-Wood F.H., PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit pongtremin 4resulting in death) Last Due to (or as a conseque attending physicien Box 68760 Physician/Medical DV7 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Whiknown 3 Ectopic pregnancy Month 4☐Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manney of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel [1 (**Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shel D D 50290 8-21-05 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tredevien , HOSP Toince 110 20678 31. Date filed (Month, Day, Year) 32. Registra s Signature State

Registrar

AUG 2 3 2005 >

State of Maryland / Department of Health and Mental Hygiene 2005 29195 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Brittany Renee Nolan August 20, 2005 2:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 Clagett Drive Rockville
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F Director 215-11-9769 19 Yrs 23, 1986 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28e-f ehow 10d. Inside City Limits other than "natural", or iteme 23a or 28e-f ehov Maryland Montgomery Rockville 1x Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 Clagett Drive 20851 USA death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Student College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental Lawrence R. Nolan ပ Marilynn R. Zappulla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health it Marilynn R. Nolan/ Mother 305 Clagett Drive, Rockville, Maryland 20851 Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any Injury or o 1 ₺ Burial 2 □ Cremation 3 □ Removal from State August 25, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spring, MD 20901 sentok 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Glioblastoma Multiforme 8 Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a sonsequence of): physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical 25 attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the a 9 Unknown 9 Unknown ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be þ 1 ☐ Yes 2 🖾 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed?
1 Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has birector, page 2 s or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No. Director: 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23308 12 August 22, 2005

State Registrar

31. Date filed (Month, Day, Year)

Victor M. Priego, M.D.



d cause of death (Item 23a) (Type, Print)

6420 Rockledge Drive, #4100, Bethesda, MD 20817

		-	1 - State of State of Registrar	Maryland / Depa	artment of He	ealth and Ment Death	al Hygier	200	5 29196
			Decedent's Name (First, Middle, Last)				ate of Death		3. Time of Death
	Physici /Medic	al	Peggy Delores Nelso		4b. City, Town, or I	AU	qust	0ay Ye 18 20 4c. County of E	05 1940 M
	Examin	er	Dorchester General	Hospital	Cambri	dee			rester
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 S	Age (In yrs. last birthday) 74 Yrs.	Months Days	Hours Min. (A	ate of Birth Month, Day, Yea Oril 5,	1931 M	Birthplace (State or Foreign Country) aryland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
8	Man Han	ctor	Maryland Dorchester	Cami	bridge				1 PYes 2 □ No
Z	death with the ms 23a or 28e	Funeral Director	701 Race St., Apt. 107	ıse	10f. Zip Code 2161	3	10g.	Citizen of Wha US	
L	Jeath Trs 2:	era	11. Marital Status 12. Was Deced			panic Origin? (Specify) , Mexican, Puerto Rican	res or No-		American Indian,
	after or ite	by Fur	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 ™ovorced Armed Force	P-No	If Yes, specify Cuban 1 ☐ Yes 2 ☑ 100		, etc.)	Specify:	White, etc.
2-00	72 hours 'neturel', dical Ex-	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupat		16b	Kind of Busine	
altimore, Maryland 21215-0036	d within 7, jiene. r than "n	Completed	Elementary/Secondary (0-12) College (1-4	lor 5+)	DO NOT use retired) Assembler		F14	ectroni	c Manufacturer
pu	al Hyg I othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (Firs	t, Middle, Maid	en <i>Sumame)</i>	C Paridiactures
ıryla	es 1 and 2 should b of Health and Ment f item 27 is marked r other treumatic a	ဥ	Howard G. Ruark 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street ar	M. Inez			te, Zip Code)
, Mê	and 2 salth a 27 Is er treu		S. Donald Wilcox/Son	5543	Mt. Holly	Rd., East	New Mai	ket. M	D 21631
ore	ages 1 of He or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from St	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	Date	20c.	Location - City	or Town, State
altin	permit. Pages Department of Importent: If it any injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	2	2 Name and Address	tery 8/20/2			e, MD
m .	P E E E	0 4	Stage where Ison	xwell 3	urran-Brom 08 High St	well Funera , Cambrida	Home,	21613	
			23a. Part T. Enter the disease, or complications that can shock, or heart failure. List only one cause on ear Immediate Cause (Final		_		oiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	ras a consequence of):	reumoni	~			
1	Examiner	-	Sequentially list conditions, b.	r as a consciousnes of r.					
	executed in and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
8760,	bul bul	dicai Ex	resulting in death) Last Due to (o	r as a consequence of);					
687	ng physical of a set the	Medic	IF FEMALE:						
. Box	Attending Physicien: The law requires that the death certific refeath. cleath. ector: After this certificate has been signed by the attending p et or the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	nt at time of death 5 [□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
P.O.	that the de ed by the detached	Phys	9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to dea		inderlying cause give	n in Part I	23e. Did tohaco	o use contribu	te to the cause of death?
Records,	w requires that been signed I should be det	ed by		fection			1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
eco	e law re has bee je 2 sho	Completed					24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
Vital F	ysicien: The is certificate hidirector, page		25. Was case referred to medical				performed		Yes 2 No
Š	ysicie s cert direct	o Be	examiner?	patient 2 ☐ ER/Outpatie	nt 3 DOA Othe	26. Place of Death (Chi		6 □Other (Specify)
Division of	ing Phys After this uneral di	on: T	27. Manner of Death 1 Natural 5 Pending (Month)	Injury 28b. Time of Injury	of 28c. Injury Work	at 28d. (Describe how in	•	
isio	Attending at death. ector: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	of Injury - At home, farm, st					r Rural Route Number,
Ö	Ital or after rel Director led in b		4 nomicide buildin	g, etc. (Specify)		V	City or Town, St	<u> </u>	
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medicai	29a. Certifier (Check only one) Medical Examiner: On the base and manner	sis of examination and/or in	th occurred at the time rvestigation, in my op	e, date and place, and d inion, death occurred at	lue to the cause the time, date	e(s) and manne and place, and	or as stated. due to the cause(s)
	To the to the total	Σ	29b. Signature and title of certifier	1117	29c. License	number	29d.	2/12/	fonth, Day, Year)
			30. Name and address of person who completed cause	of death (Item 23a) (Type				0 1 1	
		725	Dr. Eric J. Widmaier, 5	03 Byrn Stre	•	idge, MD 2	1613		
	Sta Regist	ate rar		Strar's Signature	pod				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

			1 - For Stata Ragistrar	State of Mar	укапа / Бер	artment of i	Health and M Death		ene2005	29198
	Physici /Medic		Decedent's Name (First, Middle, Last ROBERT MILRO	•	BARGER			2. Date of Deat Month AUGUST	Day Year 21, 2005	3. Time of Death 6:45AM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	
			14016 CEDARWO 5. Social Security Number 6. S		ta task birdh da		APTOWN If Under 24 Hrs.		ALLEG	
	Funeral Director		233-44-5258	רשא זרר	In yrs. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, MAY 20,	9. 8i 1930	rthplace (State or Foreign ountry) MARYLAND
	ow is		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or L	ocation				10d. Inside City Limits
	Many Pa-f sh iffed	tor	MD ALLE	GANY	CRESA	PTOWN				1 □Yes 2XINo
	or 28	Direc	10e. Street and Number	`		10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23a	rai	14016 CEDARWO			215			U.S.A.	
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or tlems 23e or 28e-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: K		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ★ No	Hispanic Origin? (Spe pan, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
215-0036	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ucation	16a Dece	dent's Usual Occup	pation	10	6b. Kind of Business	
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7	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		J.	ANITOR	18. Mother's Name	(First Middle M	MAINTEI	NANCE
Maryland		To Be	GEORGE PUFFEN	BARGER			ELSIE	WILSO		
ary	2 should and Mer Is marke aumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Rura	Route Number,	City or Town, State,	Zip Code)
	s 1 and 2 should I Health and Mer Item 27 Is marke other traumatic		RUTH D. PUFFENBA	<u> </u>			WOOD DRIVE		RLAND, MD	21502
Baitimore,	90 = 5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre				0c. Location - City or	Town, State
	permit. Pag Department Important: I any injury o		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen				RDENS 08/2		LAVALE,	MD
n D	Depa Impo any i		Chora A.	Lancher 1		UPCHURCI	H FUNERAL	HOME, P.	.A.	01500
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	Physician /Medical Examiner		shock, or heart failure. List only is Immediate Cause (Final disease or condition resulting in death)	a. METE	STATI	c Pro	STATIC	CARC	INOMA	Interval Between Onset and Death
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	cuted	Examiner		C						
Š	e exe		resulting in death) Last	Due to (or as a co	onsequence of):					
2/PU	icate be executed physician and s the burial-transit	Medical		d						
×	ding p	/Me	IF FEMALE:	23c. If yes, outcome of p	oregnancy					
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νς. Τ	requires that the een signed by thi	by Pi	Part II. Other significant conditions co	entributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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	Th ate pag	Соп						performe	ed? death?	
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5	Phys r this sral di	. To	1 Yes 2 No 27. Manper of Death	1 Inpatient	2 ER/Outpatier		4 🗀 Nursing Hom	e 5 desiden 3d. Describe how	ce 6 Other (Spec	cify)
0	nding F ath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ear) Injury	Wor	k? Yes 2 🗌 No	50. Describe 1104	rinjury occurred	
DIVISION	Atte	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S	- At home, farm, str	eet, factory, office	28	3f. Location (Stre	et and Number or Ru	ral Route Number,
5	ital or rs afte ral Dli led in	O		<u> </u>				City or Town,	772	
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier	sician: To the best of m iner: On the basis of exa and manner stated	amination and/or in	n occurred at the tin vestigation, in my o	me, date and place, an pinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	\sim 1		29c. Licens	e number	290	d. Date signed (Month	n, Day, Year)
	9 ,			10/		D00	2337	1	8-23	-05
3	120	1	Name and address of person who c	ompleted se of death		Print)	Centoed	1)	20 20	50
	Sta	te	31. Date filed (Month, Day, Year)	32. F strar's	5 Kont Signature		I HOU.U	1 1000	111) 41	302
	Registr	_	AUG 2 4 2		J. J. A	harle				
DHA	4H 17 Bev 1/20	001		-						

			1 ICUSC	State of Mandana				-	•	
			For State Registrar	State of Maryland		iment of Hi ficate of I		rental Hygid Reg	2005	29199
			1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		James	Albert	Pier	ce		August	21 2005	2240 M
	Examin		4a. Facility Name (If not institution, give			b. City, Town, or	Location of Death	3	4c. County of Death	
			Memorial Hos	pital		Easto	0		Talbot	
	Funeral	- 1	Social Security Number 6. Security Number	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		nplace (State or Foreign untry)
-	Director		215-26-2579 "	ØM 2□F 81	Yrs.	violitio Days	TIOUTS IVIII.	Feb. 12	1924 Ma	ryland
	pu >		Usual Residence of Decedent 10a. State 10b. County	100 Cit.	Take as last	41-1-2				4011-11-05-11-0
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7	death with the Maryland ms 23a or 28e-f show	Dic	10e. Street and Number	,		10f. Zip Code	4 1	10	g. Citizen of What Cou	untry?
2	ath v	ra l	10616 Hine				601		USA	
	er de	nu	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. Wa	is Decedent of Hi 'es, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	hours after turei', or ite	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	10	Yes 21 No	Specify:		Specify:	1-
21215-0036	hour ture	Completed by Funeral Director	15. Decedent's Ed		16a Decedor	nt's Usual Occupa	ation	14	Specify: B10	2CK
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Maryland	2 should be and Mental ie marked aumatic ev	F	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street a	and Number or Rur	al Route Number,	City or Town, State, Z.	ip Code)
Š	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 the Marylan Item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event. It. Medical Exam and market collines at		Elsie Pie	rce					-	
<u>ഉ</u>	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition	20b. Pla	ace of Disposit	ion (Name of	a)	Date 20	on Mary Co. Location - City or T	Town, State
Baltimore,	9 = 2		1 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify			tory or other place		7105	love Lave	Maryland
	permit. Page Department o Importent: if any injury or ance.		21. Signature of Funeral Service Licen	300 ,	22.1	Name and Address	ss of Facility	20	or ouva,	1010 1 11011 0
m	Depariment of the population o		Jane Ola r.	Henry-	He	NRY FU	Neral Ho	Me, T. H.	ridge M	D. 71/13
			23a. Part . Enter the disease, or comp shock, or heart failure. List only	lications that caused the death.	. Do not enter	the mode of dyin	g, such as cardiac	or respiratory arres	it, age, the	
	Physician		Immediate Cause (Final	A .		_				Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Metast Due to (or as a consequence)		prest	ate (ancin	2ms	
	Examiner									
D.		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	ence of):					
	s be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	C						
o,	te be execu ysician and e burial-tra		resulting in death) Last	Due to (or as a conseque	ence of):					
1760	2 2 0	Ical	(d						
68	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Completed by Physician/Med	IF FENANC.							
Вох	th ce tendii r use	an/h	230. Was decedent pregnant	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal		ctopic pregnancy			23d. Date of deli	,
	that the death ed by the atte detached for	SICI	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of dea		Other (specify)			Month	Day Year
P.0	at the de I by the etached	Phy	9 Unknown							
	res tha igned b	by	Part II. Other significant conditions co			erlying cause give	en in Part I.		cco use contribute to	
ord	w requir been si should	ted	Cononany	Anteux	UiS	-e a 5-		1 Yes	2 □No 3 □ Pro	obably 4 Onknown
ec	ne law has b ge 2 st	nple						24a. Was an autopsy	prior to c	topsy findings available omptetion of cause of
<u> </u>		Con						performe	ed? death?	20 No
Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					h (Check only one,)	
of	Phyei this c	으	1 Yes 2 No		ER/Outpatient	3□ DOA Oth	er: 4 Nursing Ho	ome 5 🗀 Residen	ce 6 Other (Spec	ify)
L C	fte	lon	27. Manner of Death 1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Injun Work	k?	28d. Describe how	injury occurred	
Sic	Attending in death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	00(1)(0)		
Division	or Al	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, ram, stree	it, factory, office		City or Town,	et and Number or Ru State)	rai Houte Number,
	pitel ours a eref I	2	29a. Certifier 1 Certifying Ph	ysician: To the best of my know	uladaa daath a	annumed at the time	an data and plans	and due to the co.		
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	(Check only 2 Medical Exam	iner: On the basis of examinati and manner stated.	ion and/or inve	stigation, in my o	ne, date and place, pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	o the	Me	29b. Signature and title of certifie			29c. Licens	e number	290	d. Date signed (Month	, Day, Year)
	->-0) m []	AP. O.	1	Doc	53110) 0.,	cised mi	2005
			30. Name and address of person who	completed cause of death (Item	23a) (Type, Pr		/ ///	F10	2031 21	700 3
			Dr. Dennis DeSh				Easton,	MD 21601	•	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ture	Smell				

DHMH 17 Rev 1/2001

James Pierre

	•		1 - For State Registrar	State of Maryland		artment of He <i>tificate of D</i>			2005	29200
Ì	D I		Decedent's Name (First, Middle, Last	it)			2.	Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Salvatore T.	Puleo					33 3005	
	Examin	er	4a. Facility Name (If not institution, give		den	4b. City, Town, or 1 Baltina			4c. County of Death	
	Funeral		5. Social Security Number 6. 9	ax 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8.	Date of Birth	9. Birth	place (State or Foreign
	Director		014-18-8765	XM 2□F 84	Yrs.	Widnis Days	J	an 1, 1	921 Ma	ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	a-fsh iffed	ctor	MD Calve	ert Pr	ince	Frederick				1 ☐ Yes 27X No
	vith the	Dire	10e. Street and Number			10f. Zip Code	70	10g	. Citizen of What Cou	ntry?
	leath v	Funeral Director	70 Wilson Court 11. Marital Status	12. Was Decedent Ever in U.S	i. 13. ¹	2067 Was Decedent of His		v Yes or No-	USA 14. Race - Amer	can Indian,
9	after d	Fun	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1941-			panic Origin? (Specif, Mexican, Puerto Ric Specify:	an, etc.)	Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examination and illied alonge.	d by	3 ☐ Widowed 4 🔀 Divorced					40		
5	nin 72 n "net	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)		16	b. Kind of Business/lo	naustry
212	od with	Som	Elementary/Secondary (0-12)	College (1-4or 5+)	Lif	e Underwr	iter		Insura	ınce
Maryland	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (F			
2	2 should be f and Mental I Is marked of raumatic eve	2	Antonio 19a. Informant's Name/Relationship (7)	Type, Print)	Puleo		Josephin		Petity or Town, State, Zi	ettinato O Code)
	and 2 seath ar n 27 ls		Richard Puleo (nne Bridge			20716
Baltimore,	it of Health If item 27 I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Pla	ace of Dispo	sition (Name of	Aug 2	200	c. Location - City or T	own, State
Ĕ	permit. Pages Department of I Important: If its any injury or o		`4 ☐ Donation 5 ☐ Other (Specify	Chu	irch C	emetery	200	5 P	rince Fred	
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licen	Goff			ern Maryla		Home Calv Owings.	
	*		23a Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the death.						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	1 11	nphon	200				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					
	7 8 1	Jer	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a conseque	ence of):					
	acuted nd transit	Examiner	cause. Enter Underlying Cause Uniscase or injury that initiated events	с						
60,	ificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a conseque	ence of):					
68760,	ifficate g phys as the	edical		d						
Box		an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		Ectopic pregnancy			23d. Date of deliv	
O.	g o g	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5□	Other (specify)		-	Month	Day Year
Δ.	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	y Ph	Part II. Dther significant conditions of	ontributing to death but not resul	Iting in the u	nderlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
rds,	en sign	ed by						1 🗌 Yes	2No 3□Pro	bably 4 Dunknown
Vital Record	taw re nas be e 2 sho	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
al	n: The licate h r, page								d? death? No 1 ☐ Yes	2□ No
Ξ.	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Minpatient 2 ☐ E	R/Outpatier	Other	26. Place of Death (C		e 6 □Other (Speci	fv)
n of	ng Phy ter thi		27. Manner of Death 1 Matural 5 ☐ Pending		28b. Time o			d. Describe how		
Siol	Attending ir death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				es 2 No	Location (Street	at and Number or Rui	el Bouto Alumbos
Division	after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		еет, гастогу, опісе	201	City or Town, S		ar noute rvamber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysicien: To the best of my knowniner: On the basis of examinati	vledge, deat	n occurred at the time	e, date and place, and	due to the caus	se(s) and manner as	stated.
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.	on and or in	29c. License			. Date signed (Month)	
)	To To		200. Signature distance of Continue	4 %				7 2	122/05	- 3/1 3//
		Simulation of the state of the	30. Name and address of person who	completed cause of death (Item	23a) (Type,			1 0	100/100	
	10+1		Eric Schwar	tzM.D. 23		recre 54	rneet Balt	more M	D 91901	
H	Sta Registr	7.0	31. Date filed (Month, Day, Year) AUG 2	4 2005 Signatu	ure K	South 1				
	-			- Jugaria	~	To bearing				

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>		of Health of Death		ental Hy	gien Reg. N	e 20	05	29	201
100	Dhusia		1. Decedent's Name (First, Middle, La.	st)					2. Date of De Month		av	Year	3. Time o	Death
1	Physici /Medio Examir	cal	MARGARE 4a. Facility Name (If not institution, giv		RIPPEON	4b. City, To	wn, or Location	of Death	August			2005	1:33	АМ
	LX		Frederick Memoria	l Hospital		Fred	lerick				Erc	deric	1-	
	- Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday	If Under 1 \	Year If Unde	er 24 Hrs.	8. Date of Bir (Month, Da	rth av Year	rie		ace (State o	or Foreign
4	Director		212-24-/26/	□M 2131F 7	7 Yrs.	WOILING E	July 3 Tiours		June 2	9,19	28		land	
12.23	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						1	0d. Inside C	it Limite
	Manyla I sho	ŏ		_1_								,		2 No
	28a-	ect	Maryland Frederi 10e. Street and Number	CK	Walkersvi	10f. Zip Co	ode			10a C	itizen of \	What Coun		
	With With	by Funeral Director	73 Main Street Ap	+ 7		217						States		
	ms 2	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.		nt of Hispanic O Cuban, Mexica	rigin? (Spe			14. Rac	e - Americ	an Indian,	
9	or Its	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N					Rican, etc.)			ck, White,		
5-0036	ral', c		3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 20	₹No Specify	y:			Specify	y:Whit	e	
5-	72 h natu	ete	15. Decedent's En (Specify only highest gra	ducation ide completed)	(Give	edent's Usual C	done during mo	st of worki	ng	16b. F	Kind of B	usiness/Ind	lustry	
2121	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Madical Exerciting Instituted at	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-)	DO NOTuse i stress	retired)			C1o	thin	g Fac	tory	
2	Hygie ther t		17. Father's Name (First, Middle, Last,				18. Moth	ner's Name	(First, Middle	Maide	n Suman	ne)		
an	d be antal	To Be	Robie Hamilton F						rie Bak		, 00,			
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "trsumatic avant, the Men	Ĕ	19a. Informant's Name/Relationship (19b. Mail	ing Address (S	Street and Numb				or Town.	State. Zip	Code)	
	ges 1 and 2 should be filed within 72 hours atler death with the Marylan it of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or itsms 23a or 28a-f show or other traumatic avant, the Madical Exam are must be notified at		Joyce Elaine Sig	ler/ daught	1		ceet P.					-		793
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Itsm 27 I any injury or other tra once:		20a. Method of Disposition		20b. Place of Disp	osition (Name matory or othe	of of place)	D	ate	20c. L	ocation -	City or To	wn, State	
Ë	Pages nent of h ant: If its ary or o		1 Surial 2 Cremation 3 ⊆ 4 Donation 5 Dother (Specif		Rocky Hi			8/23	/2005	Woo	dsbo	ro, M	ary1aı	nd
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	1900			Address of Faci	lity Star	uffer I					
m	88 5 8		Budly &	mife	4	0 Fulto	on Aveni	ue,Wai	lkersvi	i11e	, MD	2179	3	
The state of the s	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart faithe. List only immediate Cause (Figal disease or condition resulting in death)	plications that caused in cause on each line a	the death. Do not end. SUENCTI consequence of):	c C	of dying, such a	s cardiac o	respiratory a	Dise	ofe		Approximatinterval Bet Onset and 20 ye	ween Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):									
P.O. Box 6	that the death certifics ed by the attending pt detached for use as to	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	⊒Ectopic pregr ⊒ Other (specr					23d. Dai Mo	te of delive	*	/ear
of Vital Records, P	uires that signed to d be det	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the t	underlying caus	se given in Part	1.					e cause of dalbly 4 🔀 l	
Ö	w requir been si should	Completed	Redal INCU	HICIENCY					24a. Was	20	24h \	Were autor	sy findings	available
Re	he lav e has age 2	m d	1		esqu				autor	psy ormed?		prior to con death?	rpletion of c	ause of
tai		0	25. Was case referred to medical	CIAN TO ()			oe Plac	o of Dooth		2 (X No	1	I ∐ Yes	2 No	
>	Physician: The lav this certificate has ral director, page 2	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	it 2 ER/Outpatie	nt 3□ DOA	0		<i>(Check only o</i> ne 5 ☐ Resi		6 □Oth	er /Snecifi	3	
	g Physical Control of the control of		27. Manner of Death	28a. Date of Injury (Month, Day			Injury at Work?		8d. Describe				/	
0	ath.	atlo	1 ☐ Actural 5 ☐ Pending 2 ☐ Accident investigation		roar) injury	М	1 Yes 2]No						
Division	at or Attandi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, st (Specify)	reet, factory, or	ffice	2	28f. Location (: City or To			er or Rural	Route Num	ber,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	niner: On the best of and manner stat	examination and/or in	th occurred at the action of t	the time, date a my opinion, de	ind place, a ath occurre	and due to the	cause(s date an) and ma d place, a	inner as sta and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	/			icense number				-	d (Month, E		
			17796	m. Mi	0	0	0075	152		5	3/2	20/03	5	
	4		30. Name and address of person who		ath (Item 23a) (Type	Print)	1607 D	a. 1	Reden	ILK	MIS	1217	202	
	Sta		31. Date filed (Month Day Year) 2	/	's Signature	land.						0		

			1 - For State Registrer	e of Maryland	d / Depa <i>Cer</i>	artment of Hetificate of L	ealth and Mo Death	ental Hygie Reg.	ne 2005	29202
		w	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici		Cor	nelia B. R	heb			August	22 2005	3:21 P M
)	/Medic Examin		4a. Facility Name (If not institution, give street as	nd number)		4b. City, Town, or	Location of Death		4c. County of Death	
			Fairhaven			Sykesv:	ille		Carrol1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign
	Director		218 22 4661	86	Yrs.			Sept 25,	1918 Cana	ada
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c, City,	Town or Lo	cation			1	0d. Inside City Limits
	anyla sho	5								1 ☐ Yes 2 ☐xNo
	28e-1	Director	MD Carroll 10e. Street and Number	Syke	esvill	10f. Zip Code		100	Citizen of What Cour	stry?
	with with	늅	7200 3rd Avenue			21784	1			•
	death with the Maryland ms 23a or 28e-f show r nust be nutflied at	eral		Decedent Ever in U.S	i. 13. V		spanic Origin? (Spe		United Sta	
	iter d	Funeral	Ann	ed Forces? Yes 2 🕱 No	l.	f Yes, specify Cubar	n, Mexican, Puèrto F	Rican, etc.)	Black, White,	
9500-G	urs a	þ		es, Give r or Dates:	1	I∐Yes 2⊠No	Specify:		Specify: Wh	nite
Š	2 ho	pleted	15. Decedent's Education (Specify only highest grade compl	atadi	16a. Deced	lent's Usual Occupa	ation Juring most of working	165	Kind of Business/Inc	dustry
Z	en "r	ag.		ege (1-4or 5+)	life. L	OO NOT use retired))	9		
Z	filed within 72 hours after Hygiene. nther then "naturel; or Ite ant, Ira Medical Examira	Com		1	Nu	rse			<u> lealthcare</u>	2
and		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		en Sumame)	
<u> </u>	2 should be and Mental Is marked aumatic ev	ပ္	Harry O. Baker				Bertha Mi			
Z Z	2 sh and 1sm raum		19a. Informant's Name/Relationship (Type, Prin	t)					y or Town, State, Zip	,
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic	1 3	Helen B. Biles/Sister 20a. Method of Disposition	20h Pla	LU75	Old Harri	isburg Rd		ysburg PA	
ס	Pages nent of H int: If its iry or of		1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal			sition (Name of natory or other place) ark cem.			Ltimore, M	
	it. Pa rtmer rtant njury	l s	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	M0104						
g	permit. Pages Department of I Important: If it any injury or o once.	ļ,	Signature of Pulletal Service Electrises	140102					zke s ramı ott City,	ly FH Inc.
			23a. Part1. Enter the disease, or complications	that caused the death.					occ city,	Approximate
			shock, or heart failure. List only one caus	e on each line.					in missons Hi	Interval Between Onset and Death
1	mysician /Medical		disease or condition resulting in death) a.	ue to (or as a conseque		COMICST	IVE Vicher	nic care	C IN OF A IN	y .
	Examiner			50 (5) (5) 45 4 55//5544	Julian Silvi					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a conseque	ence of):					
	cuted nd ransit	Examl	that initiated events							
Ď	e exe ian aı ırial-t	Ë	resulting in death) Last D	ue to (or as a conseque	ence of):					
9/9	death certificate be executed e attending physician and id for use as the burial-transit	dlcal					-	14.2		
õ	leath certific attending p	Ψ	IF FEMALE:	707			Was 2007			
X Q	ath co	lan/	23b. Was decedent pregnant	s, outcome of pregnan Live birth 2 Petal	death 3□	Ectopic pregnancy			23d. Date of delive Month	ry Day Year
	the de y the a ached f	Physician/M	1 Vec 2 2 No 4	Pregnant at time of dea Unknown	atn 5∟	Other (specify)	-			
J.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributin	g to death but not resul	Iting in the ur	nderlying cause give	on in Part I.	23e. Did tobaco	o use contribute to th	e cause of death?
Hecords,	requires that een signed b hould be deta	d by						1 ☐ Yes	2No 3□Prob	ably 4 Unknown
ö	v req beer shou	Completed						24a. Was an	24b Were auto	psy findings available
ě	The law ate has b	E D						autopsy performed	prior to cor death?	npletion of cause of
-		ပိ	25. Was case referred to medical				26. Place of Death	1 Yes 2	No 1 □ Yes	2 No
>	ysicien: is certific director,	0 0	examiner?	1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe			6 ☐Other (Specify	/)
Ö	ig Phys ter this neral di	n: T	27. Manner of Death 28a.		28b. Time of Injury			8d. Describe how in		<u> </u>
<u>o</u>	ttending F death. stor: After the funer	atio	1 Natural 5 Pending 2 Accident investigation	(, 52)	,		res 2 □No			
Division	of or Attendie after death. I Director: Al d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
<u> </u>	itel o rs aft rel Di	Cer								
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only 2 Medical Examiner: On	the basis of examination	rledge, death on and/or inv	occurred at the time vestigation, in my op	e, date and place, a pinion, death occurre	nd due to the cause d at the time, date	(s) and manner as st and place, and due to	ated. the cause(s)
	the hin 2 the mplet	Med	29b. Signature and title of certifier	d manner stated.		29c. License	number	29d	Date signed (Month, i	Day Year)
	7 × 0 0		Los signature and the discountry	M.D.		NOO	SGOSY	230.	8/220	5
1	12			d aguag of desire (tr	22a) /T	Drint)	- 1 - 1		١٥٥١٠	
2) (je ·		30. Name and address of person who complete	C: \	V		D 31	784	Ana Car	and ann
	Sta	ite	31. Date filed (Month, Day, Year)		nia SC2D	v. 9, /1	<u>91</u>	13/	Thu Oal	MIT ///
	Registi		AUG 2 4 2005	32. Registrar's Signatu	H A	made)				

			For Stete Registrar	Stat	te of Ma	ryland / [-	nent of F				iene g. No2 (005	29203
	Physici	an	Decedent's Name (First, Middle	, Last)							2. Date of Deat Month		Year	3. Time of Death
	/Media	cal	Floyd Robert 4a. Facility Name (If not institution				4h	City, Town, or	r Location o		ugust	22	2005	11:08 P
	Examin	ner	10614 Oak Tree				45	•	iamsp			40.000		ngton
	Funeral		5. Social Security Number	6. Sex X (X M 2[7. Age	(In yrs. last bir		Under 1 Year onths Days	If Under Hours	24 Hrs. 8	B. Date of Birth (Month, Day,	Year)		lace (State or Foreign try)
	Director		212-24-3160 Usual Residence of Decedent	X4		78	113.			N	ov.13,1	926	Mary	land
	show	_	10a. State 10b. County			10c. City, Town							1	0d. Inside City Limits 1 ☐ Yes XXNo
	28a-f	Funeral Directo	Maryland Wash 10e. Street and Number	ington		<u> </u>		msport of. Zip Code			1	Og. Citizen	of What Coun	
	h with	ai Di	10614 Oak Tree	Circl	e			<u></u> p	2179	15		9	USA	
	r deat	Iner	11. Marital Status	12. Was	s Decedent E		13. Was	Decedent of H			ify Yes or No- ican, etc.)		Race - Americ Black, White,	an Indian,
36	rs afte		1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Ye	Yes 2 Ne es, Give er or Dates:	1945 – 1946		∕es 2⊠ No	Specify:		•		-14	ite
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show deal Evarta at must be multiped at	Completed by	15. Deceden (Specify only highes	's Education			Decedent's	Usual Occup	ation	st of working	,	16b. Kind of	f Business/Inc	
121	filed within 'Hygiene. ther than "ther than "ont, the Mer.	mpie	Elementary/Secondary (0-12)	T	lege (1-4or 5-		life. DO N	IOT use retired	d)	or or working			_	
d 2	filed with Hygiane. other than	Be Co	10 17. Father's Name (First, Middle,	Last)			:o-Owr	er	18. Mothe	er's Name (First, Middle, N		Compan	У
/lan	should be and Mental is marked o	To B	Floyd C. Res	ev					Alt	a J.	Sigel			
Maryland			19a. Informant's Name/Relations		-						Route Number			
	ss 1 and 3 of Health item 27 other tr		Barbara Resley 20a. Method of Disposition	- Wife				lak Ire n (Name of ry or other plac		cle W	illiams te		Maryla on - City or To	
mo	0 0		1 Burial 2 □ Cremation 1 □ Cremation 1 □ Cremation		from State			y or other plac Cemetei		ua.26.2	2005 C	lear	Spring	,Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signalum of Funeral Service	C00500	Y.		Osbe	Algoria	netfælit	y Home				
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications	that caused to	the death. Do r							por 1,11	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		Non		1260	LINS	1	mak	ome		/	Onset and Death
	/Medical Examiner	П	resulting in death)	D	ue to (or as a	consequence	of):		1	7			C	Mest
		Jer	Sequentially list conditions, if any, leading to immediate	b	ue to (or as a	consequence	of):							
	and transit	Examine	Cause. Erner Universiting Cause (Disease or injury that initiated events resulting in death) Last	С										
8760,	cate be executed physician and the burial-transit	al Ex	Tosaking in doditi) Last		ue to (or as a	consequence	OF):							
9	tificate ig phys as the	ledic		d.										
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		es, outcome o	of pregnancy	3□Ecto	pic pregnancy	,				Date of delive	•
O. E	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant at t Unknown	ime of death	5 🗌 Oth	er (specify)					Month	Day Year
<u>a</u>	es that tigned by	by Ph	Part II. Other significant condition	ns contributin	g to death bu	t not resulting in	the underl	ying cause give	en in Part I.	l.	23e. Did tob	acco use co	ontribute to th	e cause of death?
ords	w raquire baan sig should b	ted t	- Atherosc	lawie	2.						1 □ Ye	s 2 No	3 Prob	ably 4 Unknown
of Vital Records,	has by	Completed	Loron and	th	- teny	Buse	LIE				24a. Was ar autops perform	V	b. Were autor prior to con death?	osy findings available inpletion of cause of
tal		(D)	25. Was case referred to medical	,		-			26 Place	a of Death /		2 🗆 🖊 🗸	1 Yes	2 □ No
f Vi	dis X	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital	1 Inpatien	t 2□ER/Ou	tpatient 3	□ DOA Oth	or		e 5 Reside		Other (Specify	·)
	ing Ph		27. Manner of Death 1 ■ Natural 5 ■ Pendin		Date of Injury (Month, Day	Year) 28b. 1	Time of njury	28c. Injun Wor			d. Describe ho	w injury occ	curred	
Division	il or Attending Pafter death. Director: After to in by the funera	ficat	2 Accident investig	not be	Place of Inju	ry - At home, fa	rm, street, f		Yes 2 □ I				mber of Rura	Route Number,
<u>D</u>	tal or A	Certification:	4 - Homicide		building, etc.	(Specify)					City or Town	, State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier † Certifyin (Check only 2 Medical	Examiner: On	To the best of the basis of dimanner state	f my knowledge examination an ed.	dor investi	urred at the ting gation, in my o	ne, date an pinion, dea	nd place, an ath occurred	d due to the ca l at the time, da	iuse(s) and ate and plac	manner as st e, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	A	1		-	29c. License	e number		29	d. Date sig	ned (Month, L	Day, Year)
			Jules	1.		17/	(1)	175	162	3	/	hyu	17 51	1, 2005
5H-	12+1		30. Name and address of person	1 1/	d cause of de		(Type, Print	1101	m c	h. I	Cam	Aud	Rel	
	Sta		31. Date filed (Month, Day, Year)		32. Registra	's Signature	1	d a	<u>.,</u>		1	Kant	1	1
	Registr	ar	AUG 2	2005	Berly	e D.	April	a			1-	legar	strum	had

		•	For State Registrar		State of	Marylar	nd / Depa	artment rtificate			and M			2005	29204
	Di mini		1. Decedent's Name (Firs	t, Middle, Las	t)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Victoria		Swider		Ryczek					August	: 13	2005	10:20 p M
	Examin	er	4a. Facility Name (If not in		street and nun	nber)				Location of	f Death		4c.	County of Death	
			2640 Walder 5. Social Security Number		nx .	7. Age (In yrs.	last birthday)	Hunt:			24 Hrs.	8. Date of Bir	th	Calvert	
	Funeral Director		094-10-2122	. 10	M 2 ∑ F	89	Yrs.	Months	Days	Hours	Min.	July 1	9, Year)	9. Birthp Cour New	York
	p		Usual Residence of Dece	dent											
	show	'n		County		100. C	ty, Town or Lo								0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ect	MD Ca	alvert				Huntii 10f. Zip ()WI1			10a. Citiz	zen of What Cour	
	3e or	Ö	2640 Walder	n Wav					2063	39				USA	,
	death	Funeral Director	11. Marital Status	,,,,,,	12. Was Dece Armed Fo		J.S. 13.	Was Decede	ent of H	ispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Americ Black, White,	
36	or ite	y Fu	1 Never Married 2	_ 1	1 ☐ Yes If Yes, Giv	2 X) No e		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	,, 0,0,,			
21215-0036	within 72 hours atter death with the Maryland ene. then "neturel", or items 23e or 28e-f show tre Madeal Examination and the matthed at	ed by	3 X Widowed 4 □ D	Divorced Decedent's Ed	Year or Da	ates:	16a Doco	dent's Usual	I Occup	ation				Specify: whit	
7	in 72 n "nel	Completed	(Specify on	ly highest gra	de completed)	4-75.\	(Give	kind of work DO NOT use	k done d	during most	t of workir	ng	TOD. KII	IQ OF DUSTINGSWITH	dustry
212	d with giene	mo;	Elementary/Secondary 12	(0-12)	College (1	-401 5+)	ho	memak	er				(own home	:
nd	al Hy d other	Be (17. Father's Name (First,	Middle, Last)								(First, Middle	Maiden .		
yla	Meni Marker Marker Marker	10	Frank		lder,	Sr.				Broni					adka
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or items 23e or 28e-1 show any injury or other treumetic event, the Marical Examined must be mailted at ance.		Molonic D	, -		ator						gtown,		Town, State, Zip 20639	(Code)
ē,	Heall tem 2 other	1	Melanie R. 20a. Method of Dispositio		, daugi	20b.	Place of Dispo cemetery, crei	sition (Nam	e of			ate		cation - City or To	own, State
altimore,	Pages ent of nt: If i		1 X Burial 2 □ Cre `4 □ Donation 5 □ 0			State	. Stani	-			08–19	9-05	Per	ry, New	York
alti	Departm Departm Importe any inju		21. Signature of Funeral	Service Licen	see	100		2. Name and					-		
8	89 = 88		Willia	am K	7	22								ings, MD	20736
	Physician /Medical Examiner	J.	23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate care.	ure. List only	a. TRAA Due to	ach line.	quence of):							r	Approximate Interval Between Onset and Death
	t insit	Examine	Cause (Disease or injury												
o,	be executed sician and burial-transit		that initiated events resulting in death) Last		Due to	or as a conse	quence of):								
8760,	icate be physicia s the bu	icai			d.		_								
9	certificate nding phys use as the	Med	IF FEMALE:		00- 16										
Вох	atte for I	Physician/Medical	23b. Was decedent preg	nant		irth 2 ☐ Fet ant at time of	al death 3	Ectopic pre		,			2	3d. Date of delive Month	ery Day Year
o.	the d y the ched	ysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown		9□ Unkno		30	_ Cirior (spe	July						
ls, P		by	Part II. Other significant	conditions o	ontributing to di	eath but not re	sulting in the u	nderlying ca	iuse giv	en in Part I		23e. Did 1			he cause of death?
Vital Records,	law requires as been sign 2 should be	Completed										24a. Was			psy findings available
Rec	The lavate has	duuc										auto perfe	psy ormed?	prior to co death?	mpletion of cause of
ta	icien: T certificat rector, pa	O	25. Was case referred to	medical						26. Place	of Death	(Check only		1 🗆 Yes	2 No
of Vi	Ø .∞ .□	To B	examiner? 1 ☐ Yes 2 💢 No		Hospital: 1 □ I	npatient 2	☐ ER/Outpatier	nt 3 🗆 DO	A Oth	er: 4□Nu	rsing Hor	ne 5 ∑ Resi	dence 6	Other (Specif	(y)
u o		on:	27. Manner of Death 1X Natural 5 □	Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		Bc. Injun Wor	k?		8d. Describe	how injury	occurred /	
isio	ten leat tor: the	ertification;	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be		of Injugy - At h	nome, farm, st	M factor		Yes 2 🗌		28f Location /	Street and	d Number or Rura	al Route Number
Division	in Girth o	ertif	4 Homicide	determined	buildi	ng, etc. (Spec	ify)	leer, ractory,	, OITICO			City or To			ar riodio reambor,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C		Medical Exan	niner: On the b	asis of examin	ation and/or in	vestigation,	in my o	pinion, dea	th occurre	ed at the time,	date and	and manner as s place, and due to	o the cause(s)
	To the within 2 To the comple	₩e	29b. Signature and title of	of certifier	/	7		29c.	. Licens	e number			29d. Date	e signed (Month,	Day, Year)
			· CH	149	/egel	7		•	Da	635	8		AU	6-15.	2005
	10		30. Name and address of	f person who	completed caus	e of death (Ite	m 23a) (Type,	Print)		4		1-21	A	- 10	120(77)
	Sta	ato.	31. Date filled (Month, Da	iy, Year)	H - L	legistra s Sian	nature .	5-	for	que	-	11 tDE	1010	KI MI	100 10
	Regist			AUG 1	6 2005)	door	es B	ADB!	63.1						Day, Year) 2007

			For State Registrar		State of M	l arylan		artment rtificate			and M	-	giene Reg. No.2 (005	292	0.5
	Physici /Medi		Decedent's Name (First, A Richard	Do	ouglas		nambai					2. Date of De	3 ^{Day} -	OS Year	3. Time of 0	
	Examir	ner	4a. Facility Name (If not institute 203 1/2 East	Mary	Street			Cum	berl				Alleg	ty of Death any		
	Funeral Director		5. Social Security Number 218-40-3210 Usual Residence of Deceder		7. A	ge (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir Aug 1,	1941	9. Birth	place (State or ntry)	Foreign
	Maryland -f show	tor	10a. State 10b. Co		/	10c. City	y, Town or Lo	cation perland	t						10d. Inside City	
	n with the 3s or 28s	Funeral Director	10e. Street and Number 203 1/2 East	Mary :	Street			10f. Zip		1502			10g. Citizen o	f What Cou	ntry?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It is Medical Examinational be inclified at	b	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo		12. Was Deceden Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	?] No		Was Decede If Yes, speci	V	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		ace - Ameri ack, White, ify: whit	etc.	
Maryland 21215-0036	d within 72 h giene. r than "natu ir e Medical	Completed	15. Deci (Specify only h Elementary/Secondary (0-		cation e <i>completed)</i> College (1-4or	5+)	16a. Deced (Give life. labore)	dent's Usual kind of wor DO NOT use	Occupa k done d e retired)	ition <i>uring</i> mos	t of worki		16b. Kind of		,	
land	2 should be filed within and Mental Hygiene. is marked other than aumatic evant, It e Ms	To Be C	17. Father's Name (First, Mic Ovey E. Sh		ugh								, Maiden Suma Shamb			
	and 2 should salth and Men n 27 is marke ter traumatic		19a Informant's Name/Rela Elizabeth Wit	ionship (Ty	pe, Print) siste	r	19b. Majlir 34 P	ng Address Otoma	(Street a	nd Number reet	or Aura	Cumk	er, City or Town Derland	n, State, Zir	ДСоде) ДО 215	02
Baltimore,	Pa ant ary		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat 1 ☐ Donation 5 ☐ Other		emoval from State	Sun	lace of Dispo emetery crer set Men	sition (Nam natory or ot NOTIAL P	e of her place ark	9)		9/2/2005	20c. Location	-		1D
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Ser	vice Licens	Thu	1°	22					me, P.A. Cumber	land, MD	21502		
	Pnysician /Medical Examiner		23a. Park. Enter the diseas shock, of heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or compli List only or	CHRO	ed the death line.	OBST	er the mode	of dying	Pour	cardiac o	or respiratory a	rrest, DISEAS	E	Approximate Interval Betwo	
8760, <	cate be executed by sician and the burial-transit	dical Examlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Due to (or as											
.O. Box 68	ne death certiffi the attending p	Physician/Medio	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3	Ectopic pre						ate of deliver	ery Day Ye	ar .
ds, P.	luires that the signed by the detaction	by	Part II. Other significant cor	ditions cor	ntributing to death	but not rest	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco use cor Yes 2 □ No	ntribute to ti		
		Completed				·						24a. Was auto perfo		. Were auto prior to co death? 1 \(\sum \text{Yes} \)	psy findings av mpletion of cau	railable use of
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to me examiner? Yes 2 □ No	-	lospital: 1 Inpat	ient 2 🗆	ER/Outpatien	t 3 DO/				ne Resi		ther (Specif		
		tlon; T	27. Manner of Death 1 ☑Natural 5 ☐ Pe	nding estigation	28a. Date of Inj (Month, D		28b. Time of Injury		c. Injury Work	at	1		how injury occu	(-F	7)	
Division	I or Attendi after death. Diractor: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place of In building, e	njury - At ho etc. <i>(Specif</i> y	ome, farm, str	eet, factory,	office			28f. Location (City or To	Street and Num wn, State)	iber or Rura	l Route Numbe	э <i>г</i> ,
	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifier (Check only one)	ifying Physical Examin	sician: To the besi ner: On the basis of and manner s	of examinat	wledge, death tion and/or inv	occurred a vestigation,	t the time	e, date an inion, deat	d place, a	and due to the ed at the time,	cause(s) and m date and place	nanner as s , and due to	tated. the cause(s)	
	To the within To the comp	M	29b. Signature and title of ce	tifier	(2)	/		29c.	License	number)9157	,		29d. Date sign			
	l,		Paul Snow I	A.D.	mpleted cause of	death (Item						rland M	D 2150		3005	
	Sta Registr		31. Date filed (Month Per)	oarl	05 32. Sgist	trar's Signa	ture									

9			1 - For State Registrar		of Marylan	Cer	rtment of tificate o	Health of Deat	th		neg. No.	2005	
18	- Phys	sician	Decedent's Name (First, Middle		- ~ 1.1					2. Date of De Month	Day	Year	3. Time of Death
2	/Me	dical	e Falls Name (II as it six six	Barbara 1		1	45 City Town		on of Donath	August		2005	10:20P M
5	Exa	miner	4a. Facility Name (If not institution Gilchrist Cente	-	imber)		4b. City, Town		on of Death		4c. C	ounty of Death	
0			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	'I'OWS If Under 1 Ye	ar If Und	der 24 Hrs.	8. Date of Bir (Month, Da	th	Baltii 9. Birth	place (State or Foreign intry)
20	- Funei Direct		569 46 3613	1 □ M 2 🛣 F	70	Yrs.	Months Day	ys Hour	s Min.	Nov 1,	1934		ansas
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
5	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. the 21st marked other then "natural; or items 23s or 28e-f show other treumatic avent, the Medical Expansive must be notified at	Funerai Director	MD Howar	rd	Co	lumbia							1 □Yes 2 No
225	with the	F	10e. Street and Number	as Dona			10f. Zip Cod					en of What Cou	
2	eath y	erai	9498 Kilimanja:		edent Ever in U	S 13 V	2104		Origin? (Sp.	ecify Yes or No		ted Sta	
3	fter d	Fun	t □ Never Married 2 □ Mar	Armed F	orces?	l t	Yes, specify C	uban, Mexi	can, Puerto	Rican, etc.)		Black, White	
\sim	O36	by	3 ☑ Widowed 4 □ Divorced	If Yes, G Year or D	ive Dates:	1	∐Yes 2√21	No Spec	rify:		S	pecify:	31ack
(5-0 72 ho	eted		nt's Education)	(Give	ent's Usual Ockind of work do	ne durina m	nost of work	ina	16b. Kind	f of Business/li	ndustry
Barbara	21215-0036 od within 72 hours at giene. or then 'natural', or the Medical Exam	Completed	Elementary/Secondary (0-12)	College ((1-4or 5+)		OO NOT use ret	,				. 7 . 1	
3	Hygie theri	ပ္ပိ	17. Father's Name (First, Middle,	Last)	<u> </u>	500	ial Wor	-	other's Name	e (First, Middle		althcai	re
2	Maryland 2121 d 2 should be filed within th and Mental Hygiene. it? I e marked other than treumatic avant, the Me	To Be	George Brown					Lel	a Mae	Carpen	ter		
8	Aary 2 shou and M	-	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Stre	-		al Route Numb		Town, State, Zi	p Code)
Q	or Health a		Michael Schell-	-Smith/Sor					.11 Ro	ad Fred	erick	sburg,	VA 22406
F	Ore of He of He		20a. Method of Disposition 2 □ Burial 2 □ Cremation	3 □Removal from		Place of Dispo- cometery, cren	sition (Name of natory or other p	place)		Date	20c. Loca	ation - City or T	own, State
*	Fag tment tent:		4 Donation 5 Other (5	Specify)	GC		pherd C			-2005			ity, MD
SMITH	Baltimore permit. Pages 1. Depertment of He Importent: If Item	once.	21. Signature of Funeral Service	Licensee	M010								lly FH Inc. MD 21043
5		ŭ	23a. Part1. Enter the disease, o	r complications that	caused the deat	-						c City,	Approximate
	Physicia /Medic	al	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	each line.	ma			~	15m			Interval Between Onset and Death
		-	Sequentially list conditions, if any, leading to immediate	h Due to	(or as a conseq	uence of):						-	
	uted d	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated events	S									
	O, exec an an	ш	resulting in death) Last	Due to	(or as a conseq	uence of):							
	68760, tilicate be executed g physician and as the burial-ransit	ical		d.								-	
	K 68 entifica	Med	IF FEMALE:	J v			100						-
	Division of Vital Records, P.O. Box 68760 or or attending Physician: The law requires thet the death certificate be eather death. Director: After this certificate has been signed by the attending physician show the funeral director, page 2 should be detached for use as the burity.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	atcome of pregna birth 2 ☐ Feta mant at time of d nown	Ideath 3□	Ectopic pregna Other (specify)				23	d. Date of deliv Month	rery Day Year
	S, P.(es thet the igned by be detact	1 -	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the ur	derlying cause	given in Pa	art I.	23e. Did t	obacco use	contribute to	the cause of death?
	cords, w requires to been signs should be									1 🗆 '	Yes 2	No 3□Pro	bably 4 ⊡Unknown
	as been 2 should	Completed	·							24a. Was		24b. Were aut	opsy findings available
	The The page	, E								perfo	rmed? 2 No	death? 1 ☐ Yes	
	of Vital Rec hysician: The law his certificate has b	Be	25. Was case referred to medica examiner?						ace of Deat	(Check only o	one)		11
	Of \OPPRISON	ဂ္	1 Yes 2 No			ER/Outpatien 28b. Time of	3 DOA			me 5 ☐ Resi		ther (Speci	intospide
	on of ding Phy h. After the	tion	1 Natural 5 ☐ Pendi	ng (Mor	of Injury oth, Day Year)	Injury		njury at Work? I∐Yes 2		28d. Describe	now injury	occurred	/
	Division Lor Attending after death. Diractor: After	Certification:	3 Suicide 6 Could 4 Homicide detern	not be 28e. Plac	e of Injury - At hiding, etc. (Specif	ome, farm, stra y)				28f. Location (City or To		Number or Rur	al Route Number,
	DIVISIO To the Hospitel or Attendi within 24 hours after death. To the Funestel Director: A	edical C	(Check only 2 Medical one)		e best of my kno basis of examina nner stated.	owledge, death ition and/or inv	occurred at the estigation, in m	e time, date ny opinion, d	and place, death occurr	and due to the ed at the time,	cause(s) as date and p	nd manner as lace, and due	stated. to the cause(s)
	To t	Σ	29b. Signature and title of certific	er M	1 8		29c. Lice	ense numbe			1	signed (Month,	
			THE	Than	Ilile	7. m	0 De	250	302		HU	7051	17,2005
1	(0)02		30. Name and address of person	who completed cau	se of death (III	3a) (Type,	Print) N.	Cha	les.	St. B	alt	5 md	19,2005 2120x
	Cont. Sec. 62	State	31. Date filed (Month, Day, Year		legistrar's Signa		, , ,			16			
	Red	istrar	AUG 2 4	2005	Solve !	H. So	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar	State of Maryla		artment of He rtificate of D			giene Reg. No.	005	29207
	Physici /Medi	al	1. Decedent's Name (First, Middle, Last) NICHOLAS		5	SHEPPAR	2D A	2. Date of De Month UGUST	Pay	2005	3. Time of Death
	Examir Funeral Director	ner	199-14-03/4	PITAL	rs. last birthday) + Yrs.	4b. City, Town, or L BATT If Under 1 Year Months Days	MORE If Under 24 Hrs. 8 Hours Min. 8	3. Date of Birt (Month, Da)8/02/1	th y, Year)	9. Birth	place (State or Foreign ntry) PA
	Aaryland f show	ō	Usual Residence of Decedent 10a. State 10b. County MD Washingt		City, Town or Lo						10d. Inside City Limits 1 XYes 2 ☐ No
	h with the f 3a or 28a-	Funeral Director	10e. Street and Number 109 W. Franklin S			10f. Zip Code 21740			10g. Citize	en of What Cou S	ntry?
920	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Medical Exerciper must be notified at	Ď	11. Marital Status 1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	I2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🖾 No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)		Race - Ameri Black, White, pecify: B1	etc.
Maryland 21215-0036	within 72 hc ene. than "natu	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired) None	ion iring most of working	7	16b. Kind	of Business/Ir	dustry
/land 2	2 should be filed with and Mental Hygiene. Is marked other that raumatic event, the	To Be Co	17. Father's Name (First, Middle, Last) Nicholas Sheppard	, Sr.			18. Mother's Name (Mary Cart		Maiden Si	umame)	
	1 and 2 sho Health and I em 27 is ma		19a. Informant's Name/Relationship (Ty, Ronald L. Sheppar	d / Brother		ng Address <i>(Str</i> eet an nor Drive		Route Numbe DWN, MI	217	Town, State, Zij 40	Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations India and once.		20a. Method of Disposition 1 Burial 2 Cremation 3	St	nithsbur 22	sition (Name of natory or other place) g Cremato . Name and Address	or. 08/24/	2005 ald N.	Smith Minn		MD eral Home
de de la companya de	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	PULMON Due to (or as a cons Due to (or as a cons Due to (or as a cons	Path. Do not ent	EMBC		respiratory ar	rest,		Approximate Interval Between Onset and Death HOURS
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
P.O. Box (The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta		Part II. Other significant conditions con		esulting in the u		in Part I.	23e. Did to	_		he cause of death?
of Vital Records,		Completed by	HYPERLIPII MORBID (DEMIA DESITY				24a. Was autop	med?	24b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	psy findings available mpletion of cause of
of Vita	Physician: The this certificate har director, page	To Be	162 162 5 100		☐ ER/Outpatien	t 3 DOA Other	4 1 I rail sing Home]Other (Specil	y)
Division o	or Attending ifter death. Director: After in by the fune	Certification:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spe	home, larm, str		es 2 □ No	d. Describe h f. Location (S City or Tow	Street and f		al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death	occurred at the time restigation, in my opin	, date and place, and nion, death occurred	d due to the o at the time, o	cause(s) ar date and pl	nd manner as s lace, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	(MO			number 2122			signed (Month,	
3H	-/		30. Name and address of person who co	MD 2200	KERNAT	V DRIVE	BALTIMO	RE, N	1D	21207	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 6 200	32. Begistrar's Sig	H. Sp	ele					

			1 _ State	of Maryland / [Department Certificate			ental Hyg	giene 200	5 29208
			Registrar 1. Decedent's Name (First, Middle, Last)	-1	Certificate	or Dea		2. Date of Dea	leg. No.	3. Time of Death
	Physici /Media		BEHY JUNE	5	ickles			Month 08	24 03	D 1118 M
	Examir	er	4a. Facility Name (If not institution, give street and n	umber)	111000	SOWN,	ion of Death	LONA	4c. County of E	Death Serv
	Funeral Director		5. Social Security Number 6. Sex 1 M 2XIF	7. Age (In yrs. last birt	thday) If Under 1		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day March 1	(Year) 9.	Birthplace (State or Foreign Country) est Virginia
	ס		Usual Residence of Decedent					march 1	Z 1925 WE	est Virginia
	show	'n	10a. State 10b. County	10c. City, Towr						10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Director	Maryland Washington 10e. Street and Number	Hage	rstown 10f. Zip C	ode		1	l 0g. Citizen of Wha	
	th with	al Di	13911 Pontius Lane			21740			U.S.A.	•
	tams	Funeral	Armed I		13. Was Deceder If Yes, specify	t of Hispanic Cuban, Mex	Origin? (Spec	cify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
036	itied within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show int, the Medical Examinar must be notified at	by	1 Never Married 2 Married 1 ☐ Yes If Yes, C Year or	: 2 ☑ No Sive Dates:	1 ☐ Yes 2 ◘	¶No Spec	cify:		Specify:	White
21215-0036	72 hou natura	Completed	15. Decedent's Education (Specify only highest grade completed	16a.	Decedent's Usual ((Give kind of work)	Occupation	most of workin	ia l	16b. Kind of Busine	White ess/Industry
121	within ane. than "	Jdm	Elementary/Secondary (0-12) College	(1-4or 5+)	life. DO NOT use	retired)		9	,	
	Hilled Hygie other	Be Co	12 3 17. Father's Name (First, Middle, Last)	X-	-ray tech			(First, Middle, I	hospit Maiden Surname)	:al
Maryland	Menta Menta arkad atic ev	To B	James Addison Smith				Mary E	llen Wi	llingham	
Mar	d 2 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)		. Mailing Address (S					
	f Healt fam 2 itam 2 other		Doris Clayton - Friend 20a. Method of Disposition	20b. Place of	13911 Pon: Disposition (Name	of	ane, Ha		wn Md 2 20c. Location - City	
timore,	Pages nent of ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from '4 ☐ Donation 5 ☐ Other (Specify)	n State	y, crematory or othe Hill Ceme		8/25/0	05	CharlesTo	wn, W. Va.
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee	2 /	22. Name and	Address of Fa	acility Min	nnich F	uneral Ho	ome
	GD = 6 0		23a. Part1. Enter the disease, or complications that	caused the death. Do r	415 E. V	Vilson	Blvd.	Hagers	town, Mar	yland 21740
	Pnysician :	an i	Immediate Cause (Final	each line.		. ay mg, obom	. 40 0414140 01	rospilatory and	551,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to	o (or as a consequence of		_				
	Examiner	-	Sequentially list conditions, if any, leading to immediate	O(or as a consequence	FUS 10N	>			,	,
	uted d ansit	Examiner	cause. (Disease or injury that initiated events	rezely Dim	usho?	lap!	VANTRICE	Jor 54	stolic for	Tra)
Ŏ,	e exec			(or as a consequence of	of):	. SANO		1		
68760	ificate be executed g physician and as the burial-transit	edlcal	d. CO	UNTRE N	ELBO T	Dens	×5			
Box	death certifi e attending od for use as			utcome of pregnancy					23d. Date of	delivery
	0 0 0	Physician/M	in the past 2 months?	birth 2 Fetal death	3 □Ectopic pregi 5 □ Other (speci				Month	Day Year
P.0	ires that the de signed by the a l be detached i	Phy	9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to		the underlying caus	se given in Pa	art I.	23e. Did tob	pacco use contribute	to the cause of death?
Records,	The law requires that the te has been signed by the age 2 should be detache	ed by				9			s 2 □ No 3 □	
ecc	law re has be e 2 sho	Completed						24a. Was ar autops	n 24b. Were	autopsy findings available to completion of cause of
			or W					perform 1 ☐ Yes 2	No death	17
Vital	nysician: nis certifica director, p	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) Yes \(\subseteq \text{No} \) Hospital:	Inpatient 2 ER/Out	tpatient 3 DOA	Other		Check onl one	e ince 6 ⊡Other (S	inaciful
Division of	Attending Physician: ir death. actor: After this certific by the funeral director.	on: T	27. Manner eath 28a. ate 1 X Natural 5 □ Pending (Mo	of Injury 28b. Ti		Injury at Work?	-		w injury occurred	pecny)
SIO	Mtendi death. ctor: A y the fu	ertification:	Accident investigation		М	1 ☐ Yes 2		M 1 (O)		2 12
2	al or Attend s after death il Diractor: , id in by the f	Certif	determined 200. Fidu	e of Injury - At home, far ding, etc. (Specify)	rm, street, ractory, or	TICE	28	City or Town	reet and Number of , State)	Rural Route Number,
	To the Hospital or Att within 24 hours after d To tha Funaral Diract completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the Check only one) Certifying Physician: To the Check only one)	e best of my knowledge, basis of examination and nner stated.	, death occurred at t Vor investigation, in	he time, date my opinion, o	and place, and death occurred	nd due to the ca d at the time, da	use(s) and manner ate and place, and c	as stated. due to the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier		29c. L	cense numb	er1	29	od. Date signed (Mo	onth, Day, Year)
			M.S. Volumo		D	2053	30/1	(28/24/0	25, 5-6
	1-5		30. Name and address of person who completed cau	ise of death (Item 23a)	Type, Print)	Florist	The Ale	Heral	9161 E	, ail elons.
	Sta			Registlar's Signature	1.	SELINZK	JN CT	נטיעכטוי	LKHOK	wy w.
k	Registr	ar	AUG 2 5 2005	yeur B.	Spell			•		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day August 21,2005 **Physician** Mary Ellen SHANK 12:30 p.M /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 526 George Street Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthpiece (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F 220-10-3390 105 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1X Yes 2 No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21740 USA 526 George Street or Iteme 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ent: if Item 27 is marked other than "natural", or Ite 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify Specify: Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) linen room hotel unknown unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ John Wassen Eliza E. unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 George St., Hagerstown, Maryland 21740 Maude Myers - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 = 6 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or Rest Haven Cemetery 8/24/05 Hagerstown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME Ired 2,0 estor 415 E. Wilson Blvd., Hagerstown, Maryland 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ce Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) detached the 9 Unknown 9 Unknown s been signed by i should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 2X No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 20 No certificate has lirector, page 2 2 No 1 ☐ Yes 1 Yes To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 2 1 ☐ Yes 20X No 1 Inpatient Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home this Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21. Date filed (Month, Day, Year) 32. 11/10 MEDI 32. Registrar's Signature State AUG 24 2005 Registrar

Richard F. Shober, Sr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Registrar	State of Ma	arylan		artmen			ind M		giene Reg. No	-	<u> 10.5</u>	292	10
	Physic /Medi		Decedent's Name (First, Middle, L Richard	Frede	erick		Shober				2. Date of Dea Month August	Da	ĭ,	Year 2005	3. Time of 2 18:22	eath M
-	Examir		4a. Facility Name (If not institution, gi	e					Location o	d			A1:	y of Death Legany		
	Funeral Director				32	/ast birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birt. (Month, Da) 07/24/19	h y, Year) 923		9. Birthpl Count Maryla	ace (State or I try) and	Foreign
	ith the Maryland or 28a-f ehow	Director	MD A1. 10a. State 10b. County A1.	legany	10c. Cit	y, Town or Lo						10g. Cit	izen of	What Count	0d. Inside City 1 ∰Yes 2	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if Item 27 Ie marked other then "nature!', or Iteme 23a or 28a-1 ehow any Injury or other traumatic event, the Mailcal Exacting must be notified at ADGE.	Completed by Funeral Director	719 Ridge Ter 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:			Was Deced f Yes, spe-	dent of Hi cify Cuba	1502 spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Ra	JSA ce - America ck, White, e	itc.	
Maryland 21215-0036	d within 72 ho piene. r then "natur the Medical	ompleted	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 11		+)	16a. Deced (Give life.	kind of wo DO NOT u	rk done d se retired,	uring most)	of workii	ng			Store	ustry	
yland ;	outd be filed Mental Hyg Larked othe Latic event,	To Be C		asper	Shobe		•		Mary			len		Tress1		
	t and 2 sh Heelth and tem 27 le m		19a. Informant's Name/Relationship Richard F. Shober, J 20a. Method of Disposition		20b. P	1	ayette	Stree	et, Cum	mberla	and, Mary and	1and	21	-		•
Baltimore,	permit. Pages Department of Importent: If I any Injury or once.		1XXBurial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Specential Service Licential Se	fy)	1 .	nset Mer	norial	Park		08/25, Adar	/2005 ms Family	Cum	ber1	and, Ma	ryland	
6 1	90 m m g		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	inplications that caused one cause on each lin	the death	n. Do not ent		-			r respiratory arr		ryla	,	02 Approximate Interval Betwe Onset and De	
8760,	Attending Physician: The law requires that the death certificate be executed to death. Totalh. Sector: After this certificate hes been signed by the attending physicien and properties of the	fedicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d	a consequ	uence of):	he de	s Cle		<u> </u>		296	e.	10 43		
P.O. Box 6	res that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 1 4□ Pregnant at 1 9□ Unknown	2 🗌 Fetal	death 3	Ectopic pr Other (sp							ate of deliver onth [y Day Yea	ar
ords, P	w requires that been signed I should be det	þ	Part II. Other significant conditions	contributing to death bu	it not resu	ulting in the ur	nderlying c	ause give	n in Part I.			bacco u es 2[_		cause of dea	
Division of Vital Records,	ysician: The law r is certificete hes be director, page 2 sh	Completed									24a. Was a autops perform	sy		prior to com death?	sy findings ava pletion of caus □ No	ailable se of
⋚	sicial certii irecto	Be c	25. Was case referred to medical examiner? Y Yes 2 □ No	Hospital:				Othe			(Check only or		VV		CCENE	
on of	r Attending Physic death. Irector: After this I by the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day		ER/Outpatien 28b. Time of Injury		8c. Injury Work	4 LI NUI:	2	ne 5 Reside				SCENE	
Divis	To the Hospital or Attentwithin 24 hours after deatl To the Funerel Director:	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injubuilding, etc	ry - At ho . (Specify	me, farm, stre	eet, factory	, office		2	8f. Location (Si City or Town	treet an n, State	d Numl	ber or Rural	Route Number	r,
	To the Hospital or within 24 hours afte To the Funerel Direct completely filled in I	Medicai	one)	nysician: To the best o miner: On the basis of and manner stat	examinat	wledge, death ion and/or inv	estigation,	in my op	inion, death	place, a occurre	d at the time, d	ate and	place,	and due to t	he cause(s)	
	O T WE O	-	29b. Signature and title of certifier	el Xi	18	nu)		O.C	number	-			-	22, 20	*	
	200		30. Name and address of person who	King		111	Print) Penn	Stre	et, E	Balti	imore, 1	Mary	1an	d 2120)1	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3	32. Registra	rs Signat	ture	melle	,								

			1 = For State Registrar	State of M	aryland		artmen rtificate					-	005	29211
	Physici /Medic		1. Decedent's Name (First, Middle, La John C Sturtz	ist)							2. Date of Dea Month	1 ^{Day}	ď5ªr	3. Time of Death 16:00 P M
	Examin		4a. Facility Name (If not institution, gir Frostburg Villa					Town, or ostb	Location o	of Death			unty of Death legany	
	Funeral Director		723 07 8928	Sex 7. Ag	e (In yrs. Ia 79	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 3-13-19		9. Birth Cou	place (State or Foreign ntry)
	he Maryland 8a-f show offlied at	ector	Usual Residence of Decedent 10a. State 10b. County PA Somets e	t		, Town or Lo Lers by	vrg							10d. Inside City Limits 1 XYes 2 No
	h with t	al Dir	10e. Street and Number Route 1, Box 252	Main Stre	et		10f. Zip	Code 545				10g. Citizen USA	of What Cou	ntry?
036	a within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-f show It e Maracal Exstitute frout the incillist an	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 270 If Yes, Give Year or Dates:		-	Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
21215-0036	within 72 ho ene. than "natur	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	life. I	kind of wor DO NOT us	rk done a se retired,	luring mosi)		ng		of Business/In	
1d 2	e filled v Il Hygie other t vent, IL	Be Co	17. Father's Name (First, Middle, Las	")		Equip	meni	ope			(First, Middle,	Stat Maiden Sui	e govt mame)	. roads
Maryland	s 1 and 2 should be filled f Health and Mental Hyg itam 27 is marked othe othar traumatic avent,	ToB	Geroge R. Sturtz			-					E. Ken			
	nd 2 sh alth and 27 is n ir traun		19a. Informant's Name/Relationship Larry J. Stwrtz	(Type, Print)							I Route Numbe			
Baltimore,	Pages 1 a nent of Hes int: If itam iry or otha		20a. Method of Disposition 1 Burial 2 Cremation 3 County (Special County)	Removal from State	20b. Pla	ace of Dispo metery, cren tlaun	sition (Nan natory or o	ne of ther place	Darih	0.0	Mt. Sava 2~05			own, State
Balti	permit. Pages Department of Important: If i any Injury or one		21. Sign from of Funeral Sorvice Liv		1100	22	. Name an	d Addres	s of Facilit	у			Re, MD	
	Physician		Immediate Cause (Final	one cause on each III	ne.	. Do not ent	er the mode	e of dying	zerg	cardiac o	Funeral r respiratory arr	Home,	, Hyndr	Approximate Interval Between Onset and Death
8760,	/Medical Examiner	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a conseque	ence of):	ARY	ERY.	e e	(Z)	CADE		r	EN MEANY
P.O. Box 687	death certiff e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pro					23d.	. Date of delive	ery Day Year
	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death b			nderlying ca	ause give	n in Part I.					ne cause of death?
Division of Vital Records,	The law ate has b page 2 sl	Completed									24a. Was a autops perform	v		psy findings available mpletion of cause of
Vit	Physician: 1 this certifical al director, p	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	Hospitaf: 1 ☐ Inpatie	ent 2□E	R/Outpatien	t 3 🗆 DO	A Othe			Check onl on		Other (Specif	ivl
ion o	ding h. After funer	ation; T	27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day	ry 2	28b. Time of Injury		Bc. Injury Work		2	8d. Describe ho			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Divis	al or Attenders s after deat al Director: ad in by the	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injusting, etc.	ury - At hon c. (Specify)	ne, farm, stre	et, factory	, office		2	8f. Location (St City or Town	reet and Nu n, State)	u <i>mber</i> or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 Certifying P (Check only one)	nysician: To the best miner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	place, a	nd due to the ca	ause(s) and ate and pla	d manner as si ce, and due to	tated. the cause(s)
		Σ	29b. Signature and title of certifier				i i	License					gned (Month,	
7	(3)	1	30. Name and address of person who		eath (Item :	23a) (Tyne		269	07		/	rugins	1 22	2005
	Note.		Harjit S. Sidhu.	925 Bisho	p Wal	esh Rd	, Cum	berl	and,	MD	21502			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 3	2005 32. Registra	ar's Signatu	J. J	Sperk	e l						

			For State Registrar	State of	f Maryland		artment of H		and Me			005	29212
	Physici	an	Decedent's Name (First, Middle		Tae		-			2. Date of De Month	ath Day	2005	3. Time of Death 1225AM
	/Medic Examin		John John S 4a. Facility Name (If not institution	give street and nur			4b. City, Town, or			rugus	4c. Co	unty of Death	TAMONA
	Funeral		Memorial F 5. Social Security Number	10501+0	7. Age (In yrs. I		Easta If Under 1 Year Months Days	If Under 2 Hours	24 Hrs.	B. Date of Bir (Month, Da	th y, Year)	9. Birthp Coun	place (State or Foreign
	Director		071-28-7037 Usual Residence of Decedent	1LFM 2UF	74	Yrs.				Jan. 2	1, 193		w York
	Marylan f ehow	tor	10a. State 10b. County Maryland Tal	ho+	10c. City	, Town or Lo	cation Easto)ID				1	0d. Inside City Limits 1 Tes 2 -No
5	th with the Marylan 23e or 28e-f ehow	Direc	10e. Street and Number		1 D		10f. Zip Code				10g. Citizen	of What Cour	ntry? ISA
3	death w	neral	26372 Arcadia 11. Marital Status		edent Ever in U.		Was Decedent of Hi If Yes, specify Cuba	L601 ispanic Orig an, Mexican	gin? (Spec	ify Yes or No	14.	Race - Americ Black, White,	can Indian,
F-5-0036	ours after d ei', or item Executer	by Fu	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 □Yes	2 ⊡∕No ∕e		1□Yes 2☑40					acih:	hite
7 -	"natur	Completed by Funeral Director		st grade completed)	1 40551)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most	t of workin	g	16b. Kind	of Business/Inc	dustry
1212	9 A	Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,		4		Engine		er's Name	(First, Middle		Electri	С
Jarran Marvland	should be filed and Mental Hyg e marked othe sumatic event,	To Be	John T. Saran					Celi	ia (m	aiden	name ι	ınknown	·
Suranot			19a. Informant's Name/Relations Diana M. Saranc		er		ng Address <i>(Street a</i> 25 Brunel)						(Code)
, L	iges 1 and into the alth it is it item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	emetery, cre	sition (Name of matory or other place			ate		ion - City or To	
John '	permit. Pages Department of Importent: If it any injury or once.		*4 □ Donation 5 □ Other (S 21. Somethire of Funeral Service		Mid	25	Cremation(2. Name and Address Mid. Shore	ss of Facilit	hv			oride, D. Box	
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	Physician		Immediate Cause (Final disease or condition resulting in death)	-a Int	Vacia	mal	Lemor	has	pc			7	Onset and Death
	/Medical Examiner			b	(or as a conseq								
	uted d ansit	Examiner	Sequentially list conditions, I arry, cause. Enter Underlying Cause (Disease or injury that initiated events	Dire to	(or as a cons⊌q	uence of):							
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Box 68760.	ertificate ling phys e as the	Medic	IF FEMALE:	0.	teems of program								
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	v requires that the d been signed by the should be detached	þ	Part II. Other significant conditi	ons contributing to d	leath but not res	ulting in the u	indertying cause giv	en in Part I			obacco use Yes 2 🗆 N		he cause of death? cably 4 Unknown
Division of Vital Becords.	The law requite has been sage 2 should	Completed								24a. Was auto perfe 1 \(\text{Yes} \)	an 2 psy prmed?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of
Vital	Physicien: The lav rthis certificate has ral director, page 2	o Be C	25. Was case referred to medica examiner?	Hospital:	/ 00	ED/Outti-	nt 3□ DOA Oth			(Check only		Other (Specif	6.1
Jo L	ding Phys	 	27. Manne of Death 1 Danatural 5 Pendin	28a. Date	Inpatient 2 of Injury oth, Day Year)	28b. Time of Injury	of 28c. Injur Wor	ry at rk?	2	8d. Describe			у)
Oivisio	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	nined 289, Place	e of Injury - At he ling, etc. (Specif	ome, farm, st	M 1	Yes 2		8f. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,
_	Hospital 24 hours Funeral stely filled	edicai Ce		ng Physician: To the Examiner: On the b									
	To the within 2 To the comple	Med	29b. Signature and title of certifie		mor stated.		29c. Licens	se number	7		29d. Date s	igned (Month,	Day, Year)
			30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type	, Print)	, 0 0	/	LAMA	0/	1	
1	St	ate	David H. Smith 31. Date filed (Month, Day, Year) 32,7	Pintai Registrar's Signa	Drive	e Easton,	Mary	land	21601			
	Regist	rar	AUG 2 3	2005	ana A	The Allen							

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 29213 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ALISON L. SCHWARTZ AUGUST **Physician** 2005 6:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VINDOBONA NURSING HOME BRADDOCK HEIGHTS FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day MAY 26 Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) 5. Social Security Number 200-46-3638 6. Sex ^{Year)}953 **Funeral** Months Days Hours 1 M 2 F 52 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural", or Itema 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or in amount of the state of th FREDERICK MD FREDERICK 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4602 SKYLINE TERRACE 21703 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is markad oth any injury or othar traumatic event 2008: Be PAUL BRETZ BEATRICE RITTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SPOUSE 4602 SKYLINE TERR., BRADDOCK HEIGHTS. RICHARD SCHWARTZ / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 Commation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 20c. Location - City or Town, State FREDERICK CREMAT. 8/23/05 FREDERICK, MD P.C. BOX 86, BARNESVILLE, MD 21. Signature of Funeral Service Licensee 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUCT IPCE SCLENUSIS **Physician** 25 Years /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Eat at Ur Janying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Completed by Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the all a detached for 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pneumonia 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 2 □ No 1 Yes 1 ☐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Watural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifier

A / Culum 29c. License number 29d. Date signed (Month. Day, Year) 22/05 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NINIL AUE 610 Kinland 32. Paistrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 3 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 2005 29214 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yee Physician Roland Eugene Smith August 14, 2005 12:12 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth
March Dy5 year 1937 West Wirginia 5. Social Security Number 196–30–2678 7. Age (In yrs. last birthday) **Funeral** 68 1 XM 2□ F Yrs Director Usuel Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show s 23a or 28e-f shows that a state of the second sec Maryland Calvert Huntingtown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4191 Dunn Road 20639 United States Funeral is 1 and 2 should be filed within 72 hours after deal of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items other treumetic event, I'm Modical Externing to 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes X□ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 Divorced Specify. Completed by White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Man Housing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Smith Moltie Mattingley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roland E. Smith (Self) 4191 Dunn Road, Huntingtown, Maryland 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Importent: If iter
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation * 5 ☐ Other (Specify) Metropolitan Crematory 8/16/05 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, Maryland 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meta cources mon /Medical Due to (or as a consequence of): Examiner tasta ATC. mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien end for use as the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day signed by the at Id be detached fo 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? r this certificate has be eral director, page 2 st 24a. Was an 2 No 2 No 1 Yes 1 ☐ Yes or Attending Physician: Tatter death.
Director: After this certification : After this certifica e funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D0060475 30. Name and address of person who completed cause of death (Item : a) (Type, rint) RD PR. FREDERICK TEREZIA BUST, MD 100 teospita. 31. Date filed (Month, Day, Year) 32. Registrøs Signature State AUG 1 6 2005 Registrar

		1 - State Amend Item 18 Registrar 1. Decedent's Name (First, Middle, Last		em 23a,27	erlificate of	Death 84	2. Date of D	eath _	3. Time of Death
Physic /Med	ical	Linda Alia 4a. Facility Name (If not institution, give		Simmont	4h City Tourn	or Location of De	AUGUS'	19, 20	
Exami	ner	MARINA AT 8070 VE	NTIVOR ROA	D	PASADENA			ANNE A	RUNDEL
Funeral Director		5. Social Security Number 6. Se 220-60-8156 Usual Residence of Decedent	x 7. Ag ☐ M 2[X F	ge (In yrs. last birthda 51 Yrs.	y) If Under 1 Year Months Days	If Under 24 H Hours Mi	n. 8. Date of Bi (Month, D Oct. 2	70 , 1953	9. Birthplace (State or Foreign Country) Maryland
h the Maryland r 28a-1 show	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
the Ma 28a-1	Director	MD Anne Art	ınde1	Pasade	na 10f. Zip Code			10- Chicas of M	1 ☐ Yes 2 🛣 No
ith with 23a or	al Dir	8096 Ventnor Road	i		2112	2		10g. Citizen of W	nat Country?
036 vurs after dea rai', or itams Examiner m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4XX ivorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🕅 No		(Specify Yes or Norto Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc. White
1215- within 72 one. then "nai	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or : 4	5+) (Gi	cedent's Usual Occup ve kind of work done v. DO NOT use retire Employed	during most of w d)	vorking	16b. Kind of Bus	·
Maryland 2: d 2 should be filed v th and Mental Hygic t7 is marked other traumatic event, tr	To Be Co	17. Father's Name (First, Middle, Last) Ross G. Leonard		0011	шртоуса	18. Mother's N	ame (First, Middle	, Maiden Sumame	
Aarylan 2 should be and Mentat 1 is marked or raumatic eve		19a. Informant's Name/Relationship (T)			iling Address (Street				
Baltimore, M permit. Peges 1 and 2 Department of Health a importent: if item 27 is any injury or other tra once.	1	Lisa M. Jordan (I		20b. Place of Dis	4 Cape1 D position (Name of rematory or other place	1	asadena,		City or Town, State
Baltimore, bermit. Peges 1 ar Department of Her mportent: If Item iny injury or oths page.	100	1 ☐ Burial 2 🛣 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		- 1	rematory	8-2	24-2005	Baltimo	re, MD
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68760, tificate be executed ag physicien and as the burial-transit	edicai Examiner	resulting in death) Last	Due to (or as	a consequence of):					
P.O. BOX 68 thet the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	B⊟Ectopic pregnancy	,		23d. Date Mon	of delivery th Day Year
cords, P. w requires that been signed b should be deta	Ď	Part II. Dther significant conditions co	ntnbuting to death b	ut not resulting in the	underlying cause giv	ven in Part I.	1		bute to the cause of death? 3 Probably 4 Unknown
HeCo	Completed						24a. Was auto perfo	psy pr ormed? de	ere autopsy findings available for to completion of cause of path? Yes 2 \(\subseteq \) No
OT VITAL Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ent 3 DOA Oth		eath (Check only		
9 Phys er this	n: To	27. Manner of Death	28a. Date of Inju	rv 28b. Time	of 28c. Injur	4 🗆 Nursing		dence 6 NOther how injury occurre	(Specify) SCENE
Sion (ending P eath. or: After the funera	atio	1 Natural 5 Pending 2 Accident investigation	Found 5	11:40	_a ^M ¹□	Yes 2 XNo	Subject	drowned	
Division of Vital To the Hospital or Attending Physician: T within 24 hours effer death. To the Funstei Diractor: Affer this certificat completely filled in by the funeral director, ps	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et Water (ury · At home, farm, c. <i>(Specify)</i> Marina)	street, factory, office		City or To	Street and Number wn, State)8070 na, Mary 1	r or Rural Route Number. Ventnor Road and
Hospital 24 hours e Funarei I	dical (29a. Certifier 1 Certifying Phy (Check only 2 Medical Exame one)	sicien: To the best	of my knowledge, de f examination and/or ated.	ath occurred at the tir investigation, in my o	me, date and place epinion, death oc	ce, and due to the	cause(s) and man	
To the within To the	Me	29b. Signature and title of certifier Zabull	lahy	12.	29c. Licens			29d. Date signed AUGUST	(Month, Day, Year) 20, 2005
		30. Name and address of person who co	empleted cause of d		e, Print) ENN STREET	г. ват.тт	MORE. MA	RYLAND. 2	21201
St	ate	31. Date filed (Month, Day, Year)		ar's Signature			,	, 	-

		4	For State Registrar	State of M	aryland	-	rtment of tificate o		and Men	tal Hygie	2005	29216
	Physicia	an	1. Decedent's Name (First, Middle,	Last)	Stepr	101-			1	Date of Death Month ugust	Day Year 18,2005	3. Time of Death 11:43A M
	/Medic		Kebecca 4a. Facility Name (If not institution,	aire street and number		1	4b. City, Town	or Location o		ugust	4c. County of Deati	
	Examin	er	Anne Arundel	-				apoli:			Anne Ar	
					ge (In yrs. las		If Under 1 Yea	ar If Under 2	24 Hrs. 8 г	Date of Birth	9. Birti	nplace (State or Foreign
	Funeral Director		215-52-7668		84	Yrs.	Months Day	rs Hours	Min. A	Month, Day, Y ug. 15,	1921 Ma	ryland
			Usual Residence of Decedent									
	ylan how		10a. State 10b. County	nne	10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	a-f s	io N	laryland Aru	nde1			Harwo	od				1 ☐ Yes 2 ☐ No
	ith th	Dire	10e. Street and Number	D1 1	-		10f. Zip Code			10g	. Citizen of What Co	untry?
	within 72 hours after death with the Maryland ene. Than "neturel", or Itams 23e or 28a-f show he Medical Examiner must be notified at	rai	laryland Aru 10e. Street and Number 4742 Lot 0 11. Marital Status 1 Never Married 2 Married	Flanders				776			USA	2
	ar de	nue	11. Marital Status	12. Was Decedent Armed Forces	?	13. \	Was Decedent of Yes, specify C	if Hispanic Orig uban, Mexican	gin? (Specify n, Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	lf Yes, Give Year or Dates:	NO		1□Yes 2¶∏N	lo Specify:			Specify: B1	ack
21215-0036	ture	edi	15. Decedent's	s Education		16a. Deced	dent's Usual Do	cupation		16	6b. Kind of Business/	Industry
5	n "ne	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	54)	(Give life. l	kind of work do DO NOT use ret	ne during most irød)	t of working			
212	d with	mo:	10	College (1.40)	34)		House	wife			Own Hom	e
פ	at Hyg	BeC	17. Father's Name (First, Middle, L.							rst, Middle, Ma	uiden Sumame)	
<u> a</u>	uld b Menta rrked rric e	ToE	Benjamin	В	rown				sie		Brooks	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Hipportant: If Item 27 is marked other than "neturel; or Itams 23e or 28e-f show any Injury or other traumatic event, Ita Medical Exam ner must be notified at any Injury or other traumatic.		19a. Informant's Name/Relationshi Marie Tricket	p (Type, Print) t / Danei	n-law	19b. Mailir	P.O.				City or Town, State, 2	
e,	1 and 4ealth 3m 27 ther t		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of	- 1	Date	-	c. Location - City or	
٥	ages nt of l		1 ☑ Burial 2 ☐ Cremation				natory or other p		8/2	4/05 0	Thesaneal	ke Bch.,MD
Baltimore,	artme artme ortani injury	1	* 4 Donation 5 Dother (Sp. 21. Signature of Funeral Service L									
Ba	permit. Departn Imports any Inju		Glady a.	Sewell	7							me .,MD20678
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cause nly one cause on each	ed the death. line.	Do not ent	er the mode of o	tying, such as	cardiac or res	spiratory arres	t,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aC	erel	bro V	asculo	ar c	dises	25€		
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	nce of):						
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	nyn é	nce of):	nsion	•				
	ted nsit	in in	Cause (Disease or injury									
<u>~</u>	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a conseque	nce of):						
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical	1	d								
Ö	rtifica ng ph as th	Med	IF FEMALE:									
Вох	attending for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom- 1 Live birth	2 🗍 Fetal de	eath 3[Ectopic pregna				23d. Date of del Month	ivery Day Ye <i>a</i> r
	the a	Physician/Med	1 □ Yes 2 No 9 □ Unknown	4☐Pregnant a	at time of dear	th 5L] Other <i>(specify,</i>					
P.0	that the de ned by the a detached		Part II. Other significant condition	ns contributing to death	but not resulti	ing in the u	nderlying cause	given in Part I.		23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	uires I signe	d by	periphera	l vascu	lar	this e	asa	-		1 🗆 Yes	2 □ No 3 □ Pr	obabiy 4 Nnknown
20	w require been sly should b	lete								24a. Was an	24b. Were au	itopsy findings available
Re	The lay ate has page 2	Completed								autopsy performe	ed? death?	completion of cause of 2 ☐ No
ta		Ö	25. Was case referred to medical	<				26. Place		1 ☐ Yes 2 heck only one)	No 1 Yes	2010
>	Physician: this certificatal director,	OB	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 Inpat	tient 2XEF	R/Outpatier	nt 3 DOA	Other: 4 Nu	rsing Home	5 🗌 Residen	ce 6 Other (Spe	cify)
J Of	ding Pth th. After th funeral	nc.	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of In (Month, D	jury 2 ay Year) 2	8b. Time o	f 28c. le	njury at Work?	28d.	Describe how	injury occurred	
Ö	death. ctor: Af y the fu	atic	2 Accident investig	ation			M 1	Yes 2				
Division		Certification:	3 Suicide 6 Could n 4 Homicide determin	ned 286. Flace of II	njury - At hom etc. <i>(Specify)</i>	ie, farm, sti	reet, factory, offi	ce	28f.	Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	ours a		29a, Certifier Certifying	Physician: To the bes	at of my knowl	edge, deat	h occurred at the	e time, date an	nd place, and	due to the cau	ise(s) and manner as	stated.
	To the Hospital or within 24 hours after To the Funerel Directorpletely filled in b	edicai		examiner: On the basis and manner s	of examinatio							
	To the I within 2 To the Complet	×	29b. Signature and title of certifier	0	^			ense number			d. Date signed (Mont	
			X/2	orles	MD		D.	400	10		8-19-0	00.
	9		30. Name and address of person v	who completed cause of	death (Item 2	23a) (Type,	Print)	UD.	7 4 2 3	78		
	Str	ate		32. Regis	trar's Signard	re .	//		~ ,			
	Regist		31. DAUG 2 2 2005	And the second	1. 190	eu.						

			For State Registrar	ricasc	State of I	Marylan	d / Depa	artmen tificat	t of H	ealth a	and M	ental Hy	giene	200	5	29217
			1. Decedent's Name (Firs	st, Middle, Las	t)							2. Date of De Month	aath Da	y Ye	ar	3. Time of Death
	Physici /Medio			BENJAM	IIN JACC	B SHI	EN					AUG	27	2005		10:13 A ^M
	Examir		4a. Facility Name (If not in	-						Location	of Death		4c	. County of D		
			NATIONAL	-					BETH					MONTO		
	Funeral Director		5. Social Security Number	Ď	9X 7. □ M 2□ F	Age (In yrs. i	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da AUG . 2	7, Year)	.e. 1 200	Birthpl Count (AR)	ace (State or Foreign try) (LAND
	pu s		Usual Residence of Dece 10a. State 10b.	. County		10c Cib	y, Town or Lo	cation							10	Od. Inside City Limits
	Aaryla F sho	5		ONTGOME	ERY		YDS								"	1 ☐ Yes 2 ☑ No
	28a-	ect	10e. Street and Number					10f. Zip	Code	-			10g Ci	tizen of Wha	t Count	
	With With		18421 CLEA	AR SMOK	F ROAD				0841							,.
	ms 2	era	11. Marital Status	int biloi	12. Was Decede	nt Ever in U.	S. 13. \	_		spanic Or	igin? (Spe	cify Yes or No Rican, etc.)		. S . A . 14. Race - /		
ယ္	or Ite	T.	1 Never Married 2	2 Married	Armed Force	es? □XNo		tYes,spe⊲ 1 □ Yes				Rican, etc.)		Black, V Specify:	Vhite, 6	etc. N
93	rall, c	b	3 Widowed 4 D	Divorced	If Yes, Give Year or Date	s:		I ∐ Yes	2∐FNo	Specify:				Specify: *	10 11	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show ta Medical Exc. ill or transite mailled at	Completed by Funeral Director	15. D (Specify on	Decedent's Ed	ucation de completed)		16a. Deced	dent's Usua kind of wo DO NOT us	al Occupa	ition luring mos	st of workir	na .	16b. K	(ind of Busin	ess/Ind	lustry
21	Althin he.	ldm	Elementary/Secondary		College (1-4	or 5+)			se retired,)		3				
2	Hygie Hygie other t		0 17. Father's Name (First,	Middle / ast)			NOI	NE		19 Moth	or's Namo	(First, Middle		NONE		
and	otal Ped on the control of the contr	Be	KUN SHEN	Wilddie, Last)									, Maiuer	r Surname)		
Maryland	should be filed within nd Mental Hygiene. marked other than amatic event, It a Market	2	19a. Informant's Name/R	Relationshin (Tyne Print)		19h Mailir	ng Address	(Street a		SHAN	NG I Route Numb	or City	or Town Sta	to Zin	Code
<u>≅</u>	0 0 m		PUI SHAN NO)p=(/ /////			_				, MD 20	•	or rown, old	10, <i>Lip</i>	0000)
ē,	Health tem 27 other tra		20a. Method of Disposition	on		20b. P	lace of Dispo	sition (Nar	ne of			ate		ocation - City	or To	wn, State
9	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cre 1 ☐ Donation 5 ☐ 0			100	emetery, crer ATIONAI				9/4/2	005	ו אים	LS CHU	וחרנו	T 77A
Baltimore,	그 두 별 글		21. Signature of Funeral			/	22	. Name ar	d Addres	s of Facili	ty DEM	AINE EI	INER	AL HOM	F	
m	Departi Depart Impor any ir		diana	Z	Z	en	\mathbf{S}^{-52}	20 S.	WAS	HINGT	ON S	TREET A	ALEX	ANDRIA	, V	a 22314
	Physician /Medical Examiner e prival-Itausit	cal Examiner	Immediate Cause (Final disease or condition resulting in death)	3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final EXTREME PREMATIRITY (17 wks)												Interval Between Onset and Death
). Box 68760,	death certifica e attending ph d for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 □ Yes 2 □ No 9 □ Unknown			n 2 ☐ Feta t at time of d	Ideath 3□	Ectopic pi						23d. Date of Month		ry Day Year
P.0	hat th	Phy	Part II. Other significant	t conditions of	ontributing to deat	h hut not res	ulting in the u	ndertying c	alise dive	an in Part	ı	23e Did	tobacco	use contribu	te to th	e cause of death?
rds,	w requires that the been signed by th should be detache	ed by												v		ably 4 □Unknown
al Records,	The law ate has b page 2 sl	Completed										24a. Was auto perfe 1 □ Yes	psy ormed?	prior deat	to con	psy findings available inpletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to examiner?	medical	Hospital:				Othe	00		(Check only				
of	Phys r this ral dii	- To	1 Yes 2 No		i (Alinp		ER/Outpatier 28b. Time o		JA	4 🗀 🛚 🕦		me 5 Res 28d. Describe			Specify)
Division	fter	Certification;		Pending Investigation	28a. Date of (Month,	Day Year)	Injury	м	28c. Injury Work	k? Yes 2.⊑		Lou. Describe	now inju	ny occurred		
isi.	Attendi death. ctor: A y the fu	fica	3 Suicide 6	Could not be	28e. Place of	Injury - At ho	ome, farm, str					28f. Location	Street a	nd Number o	r Rurai	Route Number,
Ö	al or after	erti	4 Homicide	GOLOMINIOG	building	, etc. (Specif	(y)					City or To	wn, Stat	Θ)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Clack only one)	Certifying Ph	ysicien: To the be niner: On the basi and manne	s of examina	wiedge, deat tion and/or in	h occurred vestigation	at the tim	ie, date a pinion, des	nd place, a ath occurre	and due to the ed at the time,	cause(s date an	s) and manne d place, and	r as sta	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title	of entifier				29	c. License	number				ate signed (A		
			Y	NY (MD				0116	01613	38 (V	A)	301	4v C- 2	00	2
			30. Name and address of	person who	completed cause	of death (Item	n 23a) (Type,	Print)				L MEDI	CAL			
			CAELA MILI			JSA		A .	BETH	IESDA	MD 2	20889-5	600			
• -	St Regist	ate rar	31. Date filed (Month, Da	ay, Year) 0 7 20(72. Reg	istrar's Signa	ture	and I								
	ricgist	: 4	SEP	U (200	STATE OF STA	dian.	- 1									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 2 Date of Death nt's Name (First Middle | ast)

29218

10:35

10d. Inside City Limits 1 ☐ Yes 2 🗓 №

9. Birthplace (State or Foreign MARYLAND

VA 22314

Approximate Interval Between Onset and Death

	Physici		1. Decodarit 3 Main	CAYD	EN JEREM	IY :	SHEN						Month AUG	2 7 Da	y 2005	Year	10:
	/Medic Examir		4a. Fecility Name (I	If not institution	n, give street and nu	ımber)			4b. City,	Town, or	Location	of Death				of Death	
	LXaiiii		NATIONAL	NAVAL	MEDICAL	CEN'	ΓER			BET	HESD	A			MON	TGOM	IERY
	Funeral Director		5. Social Security N		6. Sex 1 X M 2 ☐ F	7. Age	e (In yrs. last birt	hday) Yrs.	If Under Months	1 Year Days	If Unde Hours 2	Min,	8. Date of I (Month, AUG.	Birth Day, Year)	2005	9. Birth	place (Stat intry) RYLAN
	pu 🛾		Usual Residence of	10b. County			10c. City, Town	orloc	ation								10d. Inside
	ath with the Marylar 23a or 28a-f show	Director	MD	MONTG			BOYDS	101 200	ation								1 🗆 Y
	or 28	Ire	10e. Street and Nu	mber					10f. Zip	Code				10g. Ci	izen of V	Vhat Cou	intry?
	th wit	a	18421 C	LEAR S	MOKE ROAD					2084	1			U	.S.A	•	
36	er de	by Funeral I	11. Marital Status 1 Never Marr 3 Widowed		If Yes G	orces? 2 Z/N ive	Ever in U.S. lo	1	as Deced Yes, spec		ispanic O in, Mexica Specify		ecify Yes or Rican, etc.)	No-	Blac	e - Amer ck, White	
5-00	72 hours 'netural', dical Ext	eted	(Spec	15. Deceder	nt's Education est grade completed		16a.	Decede (Give I	ent's Usua	al Occupa	ation during mo	st of work	ing	16b. K	ind of Bu	ısiness/l	ndustry
2121	e filed within at Hygiene. I other than '	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5	+)	NON		se retired	1)				NON	E	
Maryland 21215-0036	s 1 and 2 should be filed within 72 h Health and Mental Hygiene, tiem 27 is marked other than "netu other treumatic event, the Madical	To Be C	17. Father's Name KUN SHE		Last)							ier's Name	(First, Midd	dle, Maider	Sumam	10)	
	nd 2 shouth and M	_	19a. Informant's N		ship (Type, Print)								Noute Num				p Code)
Baltimore,	0 0		20a. Method of Dis 1 Burial 2 4 Donation	Cremation	3 □Removal from	n State	20b. Place of	Dispos y, crem	ition (Nar atory or c	ne of other plac	e)		ate	20c. L	ocation ·	City or T	own, State
Baltin	permit. Pag Department Importent: I any Injury o		21. Signature of Fu			Ze	, NO	_					AINE I TREET				VA 22
	30 7		23a. Part1. Enter t	he disease, o	r complications that t only one cause on	caused each lin	the death. Do n	ot ente	r the mod	de of dyin	g, such a	s cardiac o	or respiratory	arrest,			Approxim Interval 8
Ы	Physician		Immediate Cause disease or condition resulting in death)	on	a	EXT	TREME PR	EMA	TURI	TY (17 wl	ks)					Onset an
	/Medical Examiner				Due to	(or as	a consequence o	of):									
	P =	iner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nditions, nmediate	Due to	(or as	a consequence o	of):									
ć	execute in and rial-trans	Examine	that initiated events resulting in death)	3	c. Due to	o (or as	a consequence of	of):									
68760,	cate be physicia the bur	dlcal			d										-		
P.O. Box 6	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 20 9 Unknown	months?	23c. If yes, or 1 ☐ Live 4 ☐ Preg 9 ☐ Unkr	birth mant at	of pregnancy 2 Fetal death time of death		Ectopic pi Other (sp					-	23d. Dat Mo	e of deliventh	very Day
	juires that n signed b	by	Part II. Other signi	ficant conditi	ons contributing to	death bu	ut not resulting in	the un	derlying o	ause give	en in Part	l.					the cause o
I Records,	The law requir ate has been s page 2 should	Completed											pe	ts an topsy informed? s 2 🔯 No	1 8	rior to co death?	opsy finding ompletion o

28a. Date of Injury (Month, Day Year)

MD

Hospital:

3d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 🔀 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30 AVG-ZEUS

State Registrar

Be Completed by

Medical Certification; To

31. Date filed (Month, Day, Year) SEP 0 7 2005

CAELA MILLER

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 🙀 No

27. Manner of Death

1 X Natural

2 Accident

3 🗌 Suicide

29a. Certifier ne)

296

4 T Homicide

Signature a

MC USA 32 Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

Coste

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

0116016138 (VA)

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Division of Vital Records, P.O.

this certificate

To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29219 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** TYLER ADAM SHEN 2005 12:52 27 AUG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Days Director NONE 2005 MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits MD MONTGOMERY BOYDS 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18421 CLEAR SMOKE ROAD 20841 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner of filed within 72 hours after 1 Never Married 2 Married ☐Yes 2X No ö Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ģ Specify: ASIAN 3 ☐ Widowed 4 ☐ Divorced Year or Dates: neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 0 NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental KUN SHEN PUI SHAN NG 7 Is marked traumatic e ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 I PUI SHAN NG - MOTHER 18421 CLEAR SMOKE ROAD BOYDS, MD 20841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. NATIONAL CREMATORY SEPT. 4,2005 FALLS CHURCH, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DEMAINE FUNERAL HOME 520 S. WASHINGTON STREET ALEXANDRIA, VA 22314 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PREMATURITY (17 wks) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Completed by Physician/Medical attending ph I for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Hoknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? 2□ No 1 Tes of Vital 1 Yes ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ ë 1 ☐ Yes 2 ▼No Director: After the 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending 1 XNatural investigation death 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I filled IX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical completely (Check one) and manner stated To the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 0116016138 (VA) MD completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER

DHMH 17 Rev 1/2001

State Registrar CAELA MILLER

31. Date filed (Month, Day, Year)

MC

200

USA

32. Registrar's Signature

BETHESDA MD 20889-5600

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William A		Startt For State Registrer		State of M
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Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland	Cer	tificate of D	Death	Re	g. No. 200	5 29220
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	n Day Year	3. Time of Death
	/Medic		WILLIAM	ANDREW		STARTT		August	30 2005	12:22 P M
	Examin	er	4a. Facility Name (If not institution, give 3939 Roland Ave.			4b. City, Town, or Baltimor			4c. County of De	ath
	Euperal		5. Social Security Number 6. Se	-	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	irthplace (State or Foreign
	Funeral Director		216-24-3526 15 Usual Residence of Decedent	M 2□F 77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2/26/	1928 N	inthplace (State or Foreign Sountry) laryland
	death with the Maryland me 23a or 28a-f ehow rmast be notified at	'n	10a. State 10b. County MD•	10c. City	, Town or Los		altimo:	70		10d. Inside City Limits 1 XYes 2 □ No
	the N	ect	10e. Street and Number			10f. Zip Code	AT CIMO.		g. Citizen of What C	
	h with	Funeral Director	3939 Roland Av	e. Apt. 72	2		1211			l States
	eme er mi	Iner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	rerican Indian,
2-0036	n 72 hours after death with the Marylan "naturel", or fleme 23e or 28e-f ehow ealcal Exercicer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WW I		☐ Yes 2XNo	Specify:	, ,	Specify:	White
ה מ	72 ho 'natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give I	ent's Usual Occupa	uring most of wor	king 1	6b. Kind of Busines	s/Industry
7	Mithi Den Chen	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. D	OO NOT use retired)			Mallam	de i fe adi
170	be filed v ntal Hygie od other t	ပိ	17. Father's Name (First, Middle, Last)	6			cher 18. Mother's Nam	ne (First, Middle, M		e English
yland	d a b	To Be		rew Start	t Jr.		Viola		elle	Dill
	s 1 and 2 should f Health and Men item 27 is marks other treumatic	j -	19a. Informant's Name/Relationship (7)			g Address (Street a				Zip Code) 53202
Ma,	and 2 ealth a m 27 is		James D. Startt					lace Ap	t. 1301	Milwaukee,
ore,	Pages 1 and then of Healtant: If Item 5 lury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 III			sition (Name of natory or other place			20c. Location - City of	
Baitimor	mit. Pag partment portant: rinjury :		4 □Donation 5 □Other (Specify)	Car						ad, Marylan
ga	Departiment of the particular		21. Signature of Funeral Service Licens	20 Kings	1/	Name and Address			sville, eral Hon	Maryland ne, P.A.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death ne cause on each line.	. Do not ente	er the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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	/Medical Examiner			Due to (or as a consequ	ence of):					
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· ~	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):					
8/60,	death certificate be executed e attending physician and d for use as the burial-transit	Medicai				1				
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ox Rox	s death cer he attendir ed for use	Physician/	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
л О	ires that the de signed by the s I be detached f	Phy	9 ☐Unknown Part II. Other significant conditions co		ilting in the un	dashina anyaa ayaa	e in Deet I	22a Did toh	2000 line contribute	to the cause of death?
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	ding h. h. After funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 ∐No	28d. Describe hor	w injury occurred	
DIVISION	or Attending ter death. irector: After or by the fune	Certification:	3 Suicide 6 Could not be determined	286. Place of injury - At not	me, farm, stre				eet and Number or I	Rural Route Number,
ב		Cert	- I Tomoro	building, etc. (Specify	,			City or Town,	, State)	
	To the Hospital within 24 hours all You the Funeral Completely filled it	edical	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my know iner: On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manner attended and place, and di	as stated. ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mor	nth, Day, Year)
)		8		lai A		O.C.M.	Ε.	.Au	ugust 31,	2005
_	う		30. Name and address of person who can addre	1 /1-1		Print) Street, B	altimore	, Maryla	nd 21201	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 21							

State of Maryland / Department of Health and Mental Hygien 2005 29221 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** August 21,2005 Thomas Richard Thompson 5:36 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1**∑**M 2□ F Davs Hours Months 233-02-4595 Director 1959 45 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov ?7 is marked other then "neturel", or Items 23a or 28a-f shov treumatic event, It a Madical Exprisiter must be notified at TX☐ Yes 2 ☐ No Frederick Brunswick Maryland Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 1008 Peach Orchard Lane United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is merked other then "nr eny injury or other treumstic event, If a Mazili once. Elementary/Secondary (0-12) College (1-4or 5+) Public Works 12 City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Myers Charles Thompson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Peach Orchard Ln., Brunswick, MD 21716 Robyn Thompson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Mt. Olivet Church Cem. 8/24/2005 Lovettsville, Virginia * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home outher 1100 North Maple Ave., Brunswick, MD 21716 1711. Enter the dase, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shoc em an **Physician** 119 disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner epolin Sequentially list conditions, any, reading to infractional cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit 84 91 that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 ☐ Yes 2 1 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred : After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 8 0000 8 MD 1an 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Tan, M.D. 400 West 7th Street, Frederick, MD 21701 31. Date filed (Month, Day Year) AUG 2 2 32. Registrar's Signature State 2005 Registrar

			1 - For State Registrar	State of M	Marylar		artmen rtificate			and M		giene Reg. N		5	29	22	2
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	/Medi		Marie	C.	Tho	omas					August				5:15	5 a	M
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	Funeral Director		216-44-4449	1 M 2 K F	9 2	last birthday) Yrs.	Months	Days	Hours		8. Date of Birt (Month, Day July 27	, Year) , 19	13 1	Birthp Coun Vew	lace (State try) York	e or For	eign
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	r 28a	Director	10e. Street and Number	JC.L. y		TIVEL	10f. Zip	<u> </u>				10a. Citiz	en of Wha	at Coun	try?		_
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9	or It	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give			1 ☐ Yes 2		Specify:	i, rueito	nican, etc.)		Specify:	White, (Wh i			
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פ	e filec al Hyg othe vant,	BeC	17. Father's Name (First, Middle, Las	st)		1 - 22 2 3					(First, Middle,			GIIC		_	
1	uld by Wenta	To	Frederick W. Th	nomas					Hel	en V	. Lynch	ì					
Maryland 21215-0036	2 sho and / la me	•	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address	(Street a	<i>nd Nu</i> m <i>b</i> e	r or Rura	l Route Numbe	r, City or	Town, Sta	ite, Zip	Code)		
≥ ()	and ealth m 27		Carol Halderman	/Niece					errac		aithers	burg	, MD	208	386		
0	1 of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from Stat		Place of Dispo cemetery, crer	natory or ot	her place	9)		st 26	20c. Loc	ation - Cit	y or To	wn, State		
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Itams 23a or 28a-f show any infurper other traumatic event. It. Wedical Exam is considered any once.		21. Signature of Funeral Service Lice	Funeral , W, Si	Hom lver	e In	c ing,	, MD	2090	01							
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9		- au 1	IF FEMALE:											- 1			
Вох	The law requires that the death certific Ite has been signed by the attending p age 2 should be detachad for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	Ideath 3	Ectopic pre					23	d. Date of Month		y Day	Year	
0	res that the de signed by the a be detachad t	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of d	eath 5	Other (spe	cify)					WOIGH		Jay	i cai	
٥.	that the ded by detail	/ Ph	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tot	pacco use	contribu	te to the	a cause of	death?	
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	To the Hospital or Attanding Physician: within 424 hours after death. To the Funeral Director Aller this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	0. 0			29c.	License	number		25	d. Date :	signed (M	onth, D	ay, Year)		
)	8		Shuew	dhat	Ru	5. M-	2	D57	7630			Augus	st 21	., 2	005		
			30. Name and address of person who				,										
			Arun Anuradha,	M.D. 1030	Ol Geo	orgia A	Avenue	, #2	209,	Silve	er Spri	ng, I	Maryl	and			
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 2 3 20	34. Regis	trans Signa	ture 423	(c)										

		-	For State Registrar	State of	Maryland		rtment of H			iene •g. No 2 0 0 5	5 29223
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	Funeral Director		LIONS MANOR 5. Social Security Number 236–20–9634		HOME . Age (In yrs. Ia:	st birthday) Yrs.	CUMBE ff Under 1 Year Months Days	RLAND If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		ANY irthplace (State or Foreign Country) ARYLAND
ler.	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County WV MI	NERAL		Town or Lo					10d. Inside City Limits 1 □ Yes 2 ☑ No
ap	of after death with the Maryland or itams 23a or 28a-f show miner must be rediffed at	Funeral Director	10e. Street and Number POPLAR STRE				10f. Zip Code 2675			U . S . A .	
950	urs after des ai', or itams	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🏋 Widowed 4 ☐ Divorced	ried 1 X Yes 2	2 □ No		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2X No		pecify Yes or No- p Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
Melvin	DESITIMOTE, INICITYICILIC ZICIOOSO permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiens Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 1 2	nt's Education st grade completed) College (1-	4or 5+)	(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	during most of wor	king	16b. Kind of Busines	-
Me	vid be filed Mental Hygi riked other	To Be Co	17. Father's Name (First, Middle, ROBERT TAB						, , ,	Maiden Sumame) USEHOLDE	
0	e, Mary		19a. Informant's Name/Relation: DORRIN ARMENT 20a. Method of Disposition		20b. Pla	ROUT	E 1, BOX sition (Name of	256, RI	DGELEY,	r, City or Town, State WV 26753 20c. Location · City	
8	altimor mit. Pages partrient of I portent: If it, y injury or o		1 Burial 2 Cremation 4 Donation 5 Other (3	Specify)	tate I	TLAWN	MEML • GAR	DENS 08/2	- All	LAVALE,	MD
2	Dermi Depar Impor		23a. Part1. Enter the disease, o shock, or heart failure. Lis	/			UPCHURCH 202 GREE er the mode of dyin	NE STREE	r, CUMBE	RLAND, MD	21502 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (d	or as a conseque		of un	7			3 Month
	8 / 60, rate be executed obysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	or as a consequent						
(Division of Vital Records, P.O. Box 68/60, To the Hospital or Attanding Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial pure that the pure completely filled in by the funeral director, page 2 should be detached for use as the burial pure that the pure	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Fetal ant at time of de	death 3□	Ectopic pregnancy Other (specify)	/		23d. Date of o Month	delivery Day Year
	Cords, P. w requires that the second by should be detailed by	by	Part II. Other significant condit	ions contributing to de Melletus	ath but not resu	lting in the u	ndertying cause giv	ren in Part I.	23e. Did to		e to the cause of death? Probably 4 □Unknown
!	al Reco : The law re cate has bee , page 2 sho	Completed								prior to death 2 No 1 1 Y	
	of Vital F Physician: The rr this certificate or oral director, pag	To Be	25. Was case referred to medic examiner? 1 Yes 25 No 27. Mapner of Death	Hospital: 1 🗆 Ir	npatient 2 E	28b. Time o		ner: 4 Nursing H		ne) lence 6 Other (S now injury occurred	pecify)
	Division of Vital Records, do a vatanding Physician: The law requires to after death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be	ertification;	3 Suicide 6 □ Could	tigation and the second		Injury me, farm, st		Yes 2 □ No	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
	Divisor To the Hospital or Atterwitin 24 hours after determine 14 hours after detector To the Funeral Diffector completely filled in by the	edica C	(Check only 2 Medica	ing Physician: To the Il Examiner: On the ba and mann	isis of examinat	vledge, deat ion and/or in	vestigation, in my o	ppinion, death occu	urred at the time, o	date and place, and o	due to the cause(s)
	4	Σ	29b. Signature and title of certif	The	-6	22-) (T		00332		29d. Date signed (Mo	2, 2005
((1) = 18)	ate	30. Name and address of persons o	9 MD G.	e of death (Item	otis	10e., C	umberla	nd, M	2150	2
	Regist			3 2005	Vereus	K.	porti				

		•	For State Registrar		State o	f Marylan		artment rtificate			and M		giene Reg. No	$Z \cup U$	5	29224
			1. Decedent's Name (First, A	liddle, Last	")							2. Date of De	ath Da	v \	′ear	3. Time of Death
	Physici: /Medic		Katherine	e Mil	lls To	wers						August				2:20 a. ^M
	Examin		4a. Facility Name (If not insti			mber)				Location o	of Death		40	. County of		-4
			1705 Hamb			7 4 //	for and the Coulombia and the coulombia	If Under	mbri	If Under:	24 Hrs	O Data of Ric		Dor		
	Funeral Director		 Social Security Number 214-07-7395 	6. Se	× □M 254F	7. Age (In yrs. 87	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept. 1	y, Year)	1917	Cou	place (State or Foreign ntry) rvland
			Usual Residence of Deceder							<u></u> '		-1			т	
	show	_	10a. State 10b. Co	-	at ass	10c. Cit	y, Town or Lo		mbaa	daa						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	18e-f	Director	MD D	orche	ster			10f. Zip	mbri	lage	_		10a Ci	tizen of Wh	at Cau	
	with I	ij	1705 Hambr	ooks i	Blvd.			TOI. ZIP	Code	2161	3		109.01	USA	at oou	indy:
\mathcal{Z}	death	era	11. Marital Status		12. Was Dece	edent Ever in U	.S. 13.	Was Deced	ent of Hi			ecify Yes or No Rican, etc.))-			can Indian,
ر 92	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Ie marked other than "naturel", or items 23a or 28e-f show other treumatic event, the Modical Examinal must be notified at	by Funeral	1 ☐ Never Married 2 ☐ 3 1 Widowed 4 ☐ Divo		Armed Fo 1 ☐ Yes If Yes, Gir	2 No ve		rves,spec 1 □ Yes 2		Specify:	i, Puerto	нісап, екс.)		Specify:	White,	etc. nite
21215-0036	hours			edent's Edu	Year or D	ates:	16a. Dece	dent's Usua	I Occupa	ition			16b. K	ind of Busi	ness/Ir	idustry
215	hin 72	Completed	(Specify only h		College (1-4or 5+)	(Give	kind of wor DO NOT us	k done d e retired,	u <i>ring m</i> osi)	t of worki	ng				
2	ad wit	Con	11					line w	orke					elec		nics
Maryland	d 2 should be filed within ' h and Mental Hygiene. 7 le marked other then " treumatic event, the Mas	Be	17. Father's Name (First, Mic		Milla							e (First, Middle eonard	, Maider	Sumame)		
Z	should nd Mei mark matic	ဥ	19a. Informant's Name/Rela				19b. Mailii	ng Address	(Street a			al Route Numb	er, City	or Town, Si	ate, Zij	Code)
Ma	nd 2 suith ar 27 le r treu		Wayne Towe			son	311 (Cambri	dae	Land	ing.	Cambri	.dae	, MD	216	513
ore,	of Hear		20a. Method of Disposition 1 Surial 2 Crema		Demount from		Place of Dispo	sition (Nam	e of			Date		ocation - C		
ij	Page ment ent: It		`4 □Donation 5 □Oth				een Lav				8/24	/05	Car	mbrid	je,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree		21. Signature of Funeral Se	vice Licens	500			2. Name and			111	omas Fu bridge,		al Hor 216		P.A.
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_	a	lymp	home	し								Iyear
	/Medical Examiner		resulting in death)		Due to	(or as a conseq	juence of):									1
		er	Sequentially list conditions, if any, leading to introducte		b. Due to	(or se d donesq	juence of):									
	cuted	Examiner	if any, leading to introvulate cause. Enter Underlying Cause (Disease or injury that initiated events	1	c											
90,	cate be executed physician and the burial-transit	Ex	resulting in death) Last		Due to	(or as a conseq	(uence of):									
8760,	cate b physic the b	dical			d									··········		
9 x	E 00 8	/Me	IF FEMALE: 23b. Was decedent pregnar			tcome of pregna								23d. Date	of deliv	ery
. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	in the past 12 months?		4☐Pregr	oirth 2 ☐ Feta nant at time of d]Ectopic pre] Other (spe						Mont	n	Day Year
P.0	at the by th	hys	9 Unknown		9□ Unkn							an Biss				4 4 4 4 6
Records, I	w requires that the sbeen signed by the should be detache	ρ	Part II. Other significant co	nditions co	entributing to d	eath but not res	sulting in the u	nderlying ca	ause give	en in Part I.		1 🗆				the cause of death? bably 4 Unknown
000	- D (0	Completed										24a. Was		24b. We	ere auto	opsy findings available ompletion of cause of
Re	9 L 9	mo										perfe	ormed? 2 No	de	ath?	2□ No
Vital	ysicien: The is certificate director, pag	Be (25. Was case referred to me examiner?		I I A-I				0.1			(Check only				
	Physicien: this certific ral director,	은	1 ☐ Yes 2 No				ER/Outpatie					me 5 Resi 28d. Describe				fy)
uo.	ding After fune	tlon		ending vestigation	28a. Date (Mon	th, Day Year)	Injury	M	8c. Injury Work 1 □ \	rat res 2 □		200. 0050:100	riow iriju	ry occurred	4	
Division of	Attending r death. ector: Atter	ifica	3 ☐ Suicide 6 ☐ C	ould not be	200. Place	of Injury - At h	ome, farm, st	reet, factory	, office			28f. Location (City or To	Street a	nd Number	or Rur	al Route Number,
Ö	tel or rs afte el Dir	Certification:	4 Normalds		Dulid	ing, etc." (Specil						0.1, 0. 70				
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical			iner: On the b	e best of my kno easis of examina ner stated.										
	To the within 2 To the complete	M	29b. Signature and title of c	entifier /	15.	. AT.		29c	. License	number	0-1		29d. Da	ite signed	Month.	Day, Year)
			· OM	d to	Su	WWA	•		P	2750	5/		8	122	10	١.
			DOVID SMIT	rson who o	ompleted cau	se of death (Iter 29406	Pinta	Print) D	rive	-Su	ite	5, Ea	Sto	ni	ML	21601
	Sta Regist		31. Date filed (Month, Day,	(ear)	005 32	Registrar's Signa	ature									

		•	For State Registrar	State of Man		artment of			giene Reg. No. 2005	29225
	Physici /Medic	an	1. Decedent's Name (First, Middle, L		thon	TAS.		2. Date of De	Day 2005	3. Time of Death
	Examin	er		lursing and	Rehab n yrs. last birthday)	4b. City, Town, Salls If Under 1 Yea	or Location of Debuny		4c. County of D	nico
	Funeral Director		493 - 38 - 5690 Usual Residence of Decedent		8 Yrs.	Months Day		Min. (Month, Da 04-2	8-37 m	Birthplace (State or Foreign Country)
	ath with the Maryland 23e or 28e-f ahow	ctor	10a. State 10b. County DE Suss		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	with the a or 28 be no		10e. Street and Number	201 2015		10f. Zip Code	9950		10g. Citizen of What	Country?
980	or items	by Fur	7 322 VICTOR 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13.		f Hispanic Origin? uban, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)	14. Race - A Black, W	merican Indian, 'hite, etc. 'WHITE
21215-0036	within ene. than "	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or 5+)	(Give	DO NOT use reti	ne during most of		16b. Kind of Busine	,
Maryland 2	should be filed and Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Las	BRIAN	THOMA	S	18. Mother's I	Name (First, Middle	MAK	
Mar	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		19a. Informant's Name/Relationship SHIRLEY TH			3-5		Rural Route Numb	er, City or Town, State	e, Zip Code) 19950
Baltimore,	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other p	place)	- 22 - 05	20c. Location - City GEORGE 1	or Town, State
Baltii	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	- 7	22	Name and Add	tress of Facility	MERAL H GRRENU	BME	19950
8760,	Physician /Medical Examiner phural-Itansit	Ical Examiner	23a. Part1. Enterthe disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a condition of the con	onsequence of):	Demen		diac or respiratory a	rrest,	Approximate Interval Between Onset and Death 10 4 cms
.O. Box 6	at the death certificate by the attending physicached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of particles of the last of the	Fetal death 3	∃Ectopic pregnar ∃ Other (specify)			23d. Date of Month	delivery Day Year
Il Records, P.	The law requires tha ate has been signed page 2 should be de	Completed by Pl	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	nderlying cause	given in Part I.	1 1 24a. Was	Yes 2 No 3	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA	Other	Death (Check only	one) dence 6 □Other (S	inectiful.
of	ing After une		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of Injury (Month, Day Y		f 28c. In			how injury occurred	рвспу
Division	i Pit e	Certification;	3 ☐ Suicide 6 ☐ Could not determine		- At home, farm, str Specify)	reet, factory, office	ce .	28f. Location (City or To		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	Medical		Physician: To the best of naminer: On the basis of ex and manner stated	amination and/or in					
	To the within To the comple	ĕ.	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signed (M	onth, Day, Year)
•	8-12		> neath			Ţ	057359		August	1815 2005
7	200		30. Name and address of person wh	o completed cause of deat	h (Item 23a) (Type,	Print)	VISION	ST, SALA	BYRY M	1) 2180 4
	Sta Regist		31. Date filed (Month, Day, Year)	9 2005 32. Redistrar's	Signature &	Sports		•		1815 2005 D 21804

			State of Maryland / Dep.	artment of Health and Mertificate of Death		211115 29226
			Registrar 1. Decedent's Name (First, Middle, Last)	Timcate of Death	2. Date of Death	3. Time of Death
	Physicia	an	Frederick Stanley Keith Tyrrell		Month August 22	Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 22	4c. County of Death
	Examin	er		Prince Frederick		Calvert County
	Funeral		Calvert County Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y	
н	Director		372 – 22 – 3313 ¹ X ^M ² □ ^F 79 Yrs.	Months Days Hours Min.	April 16	. 1926 Michigan
	p _		Usual Residence of Decedent			104 levide 0'' 1''
	show	_	10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 X No
	8a-f	Director	1110	rederick	10.	
	with the	<u>i</u>	10e. Street and Number	10f. Zip Code		. Citizen of What Country?
	s 23	Funerai	125 Allnutt Court 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20678 Was Decedent of Hispanic Origin? (Spe		U.S.A. 14. Race - American Indian,
	Item Item	Ä	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
99	urs af	by	1 ☐ Never Married 2 ☐ Married 1 【X Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28a-f show frs M. Jical Ex., citrer, ust be natilied at	Completed		edent's Usual Occupation s kind of work done during most of working	16	b. Kind of Business/Industry
215	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
2	ygien ygien yer th	Ç		tographer		ederal Government
and E	be fill	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name Naomi Ma		iden Sumame)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I Health and Mental Hyglene ritem 27 Is marked other then "naturel", or Items 23e or 28a-f show ther treumatic event, I're M. Jical Ex., citier round be notified at	ို	Stanley Tyrrell 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street and Number or Rura		City or Town State Zin Code
Ma	d2s than t7 ls i		1111	Amber Way, Owings,		
	is 1 and is Health item 27 other tr	l i	20a Method of Disposition 20b. Place of Dispo	osition (Name of D	ate 20	c. Location - City or Town, State
20	ages ant of it: If i		1 X Burial 2 Cremation 3 C Hemoval from State		•	lington, Virginia
Baltimore,	permit. Pages 'Department of H Importent: If ite eny Injury or ot	1		22. Name and Address of FacilityLee		
ä	Depa Impo eny Ir					, Owings, MD 20736
			23a. Part1. Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Interval Retween
	Physician		Immediate Cause (Final disease or condition	Non-Small	Cell L	ung Conce and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	100 101 11		
	Examiner		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and and il-tran	Examine	that initiated events c. Pue to (or as a consequence of):			
8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dicai E				
687	ificate g phy: as the	edic	U			
Вох	eath certific attending p	M/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 {	Other (specify)		Month Day Year
P.0	at the de by the stached	hy	9 Unknown			
	The law requires that ite has been signed b age 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		cco use contribute to the cause of death? 2 \(\sum \text{No} \) . 3\(\sum \text{Probably} \) 4 \(\sum \text{Unknown} \)
ecords,	w require been sign	ted			i Tes	2 No 3 Probably 4 Unknown
ec	has b	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
<u>E</u>		Co				No 1 Yes 2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
of	Phys r this ral di	- To	27. Manner of Death 28a, Date of Injury 28b. Time of	ent 3 DOA Wursing Hor	ne 5∐ Hesideno 28d. Describe how	ce 6 Other (Specify) injury occurred
on	Attending I r death. sctor: After by the funer	tior	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		
Division	of or Attendiater death. Director: A d in by the fu	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number,
Ö	s afte	Certification:	4 Homicide building, etc. (Specify)		Ony of Yours,	State)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a	and due to the caus	se(s) and manner as stated.
	To the H within 24 To the F complete	Medical	one) and marrier stated.			
	Vitl To Con	=	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, Day, Year)
7				033123		0 000
ı	0+1		30. Name and a ress of person who completed cause of death (Item 23a) (Type Jonathan D, Lowenthal, M.D. 110 Hospi		Frderick	. MD 20678
	Sta	ite	31 Date filed (Month, Day, Year) 32 Registra Signature		- I GOI ION	, 200 to
	Registi		AUG 2 4 2005 € Blown &	Grande		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 29227 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 12:15 P^M 2005 MARY UPCHURCH WILLIS August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Manor Care Nursing Home 8. Date of Birth (Month, Day, Year Jan. 31, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 9. Birthpface (State or Foreign 5. Social Security Number **Funeral** North Carolina 1 M 2 K 1928 Director 238-36-3041 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Director Riverdale Park Prince George's MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20737 5017 Oglethorpe Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) Dutchmaid Clothing Sales 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic evant sone. 17. Father's Name (First, Middle, Last) Be Mattie Cassie Cole Herman Edwin Upchurch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 715 Hickman Drive, Ocean View, DE Joseph Willis, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 108/27/2005 Benson, North Carolina Roselawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Dasch Jarning 4739 Baltimore Avenue, Hyattsville, Maryland Claudelle 23a. Part1. Enter the disease, or complications that caused the death. Po not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Failure disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the burial-transit that initiated events iding physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Peripheral Vascular Disease 1 Yes 2 No 3 Probably 4 Vunknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus has autopsy performed? 1 Ves 1 ☐ Yes 2 ☐ No 2X No 25. Was case referred to medical examiner? Physician: Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2X No 3∏ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To tha Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 2 3 2005

SHEVAN

30. Name and address of person who completed dauge of death (Item 23a) (Type, Print)



PERMANENTE

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Hospital or Attending

State of Maryland / Department of Health and Mental Hygien 2 1 5 29228 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 19 ay **Physician** 2**00**5 4:10AM WILLOBY JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Center Clinton Prince George s If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 31, 10 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1X M 2 ☐ F 60 577-58-6511 1944 Director Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is markad othar than "natural", or items 23a or 28a-f sho traumatic avant, the Medical Examinar must be rediffed at 1 Ves 2 □ No Director Prince George's Maryland | Clinton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 4805 Plata Street USA Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. octant: If item 27 Is markad othar than injury or othar traumatic avant, the Markal Elementary/Secondary (0-12) College (1-4or 5+) Facilities Specialist Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Catherine Smith Edward Willoby, Sr. 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Deborah Kelly Willoby 4805 Plata Street Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Mt. Olivet Cemetery 8/26/2005 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of 1 eral Service Licenses 4001 Benning Road, NE Washington, DC 23a. Part1. Enter the disease, or comprise tons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEP515 /Medical Due to (or as a consequence of): **Examiner** MELLITUS DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MULTI ORGAN SYNDROILE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 □ No or Attending Physician: completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**X**No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Jisomosom) D48158 AUG 19, 200 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DXON HILL MD 20745 OXON 6192 HILL ROAD STE 500 SISOM OSIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 2 3 2005

05-05537 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 John Edward Ward Jr. 29229 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 16, 2005 ar **Physician** 0324 А. м Ward, John Edward Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct 20, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1**X** M 2□ F Yrs. 1970 Wash. Director 34 214-11-2431 Usual Residence of Decedent 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits or than "natural", or iteme 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 15 Waldmann Mill Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) firefighter fire service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nd Mental marked o Carole Lee Cochran John Edward Ward. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i 15 Waldmann Mill Court, Perry Hall, MD Teri Nicole Ward, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If any Injury or once. Mt. Harmony Cemetery | 08-19-2005 Owings, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai attending for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) the c 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autoosy performed' certificate 2 No 1/X Yes 2 No es of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □XYes 2 □ No 1 Mnpatient 2 ER/Outpatient 3 DOA this iours efter death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 28b. Time of Division 1 Natural 5 Pending investigation Proper clist struck out 92 1 ☐ Yes 2 No 0 Accident 28f. Location (Street and Number or Rural Route Number, City or Town/State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide 6 2250 E To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number O.C.M.E. August 16, 2005

Registrar

State

31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore Maryland 21201

ho completed cause of death (Item 23a) (Type, Print)

Modern 1

32. Registra

			For State Registrar	State of M	aryland / Depa	artment of I				iene . .g. No.2 ()	0.5	29230
	Dhuaisi		1. Decedent's Name (First, Middle, La	,				N.	ate of Deat		Year.	3. Time of Death
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					14	Od. Inside City Limits
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	ath w	rai	857 Clubhouse Vil				1401			Unite		
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. If a Medical Examination and item collised at	by Funeral	11, Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1 Yes 2 X If Yes, Give Year or Dates:	? No	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🔯 No			Yes or No- n, etc.)	Bla	ce-America ck, White, o fy: Whit	etc.
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Baltimore,	permit. Pages 1 and 2. Department of Health al Important: If item 27 Is any injury or other trauonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	☐Removal from State	20b. Place of Dispo	sition (Name of natory or other pla	ace)	Date Date				21401 wn, State aryland
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Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not to determine to		njury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office			ocation (Str City or Town		per or Rural	l Route Number,
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}	Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, 1	Town, or	Location o	of Death		4c. County	of Death	
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	Funeral			.Sex 7 12X1 M 2 □ F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Oay	Year)	9. Birth	place (State or Foreign ntry)
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	Principles .		shock, or heart failure. List or Immediate Cause (Final	nly one cause on ea	Ala.	. /	3	· .	10	0.	1. 110	a noth		Interval Between Onset and Death
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Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Fetal	death 3	Ectopic pre						te of deliver	ery Day Year
_	the all	Physician/Me	1 Tes 2 No	4⊟Pregna 9⊟Unkno	ent at time of de wn	eath 5	Other (spe	ecify)						,
P.O.	requires that the death certific een signed by the attending p hould be detached for use as		Part II. Other significant condition	s contributing to dea	ath but not resi	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use con	tribute to t	he cause of death?
Records,	signed d be del	Completed by	Hu Ope + Pus	ion	Reni	2/ 1	ailu	10	Pac	Checo	4/ 10Y	es 2□No	3 Prot	pably 4 proknown
ő	w requir been si should I	etec	1	1	7	-			1/6		24a. Was a	24h	Wore auto	aney findings available
3ec	hes hes	ם	VASCICIA!	SPASE	1-6	on o	C+ic	ieuc	-4 H	hem .	autops	med?	prior to co death?	ppsy findings available mpletion of cause of
a			Lott eye bl	induess,	054	COACH	hrit	is,	Sel	515		/	1 🗆 Yes	2DXN0
Vital		Be C	25. Was case referr to medical examiner?	Hospital:	patient 2	ED/Outration	. 200	Othe		of Death ursing Hom	(Check only or	ne) ence 6 ⊟Oth	or (Coori	
ō	Phys r this ral di	1: To	1 ☐ Yes 20 No 27. Manner of Death	28a. Date of	f Injury	ER/Outpatier 28b. Time o		Bc. Injury Work	4 🗀 140		8d. Describe h			y)
O	ding th. : Afte	ţ	Natural 5 Pending 2 Accident investiga		n, Day Year)	Injury	м		? ′es 2 ∐i	No				
Division	Attending r death. sctor: After y the fune	Hice	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Place	of tniury - At ho	me, farm, sti	eet, factory,	office	*	28	Bf. Location (Society or Town	treet and Numb	er or Rura	al Route Number,
Ö	s afte	Certification;	4 Homicide	Dulidin	g, etc. (Specify	′/					City of TOWN	n, State)		
	Hospitei 24 hours a Funerei i tely filled			Physician: To the l										
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral i	Medical	one)	and mann										
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1		0	29c.	License	number	11/1	5 2	29d. Date signe	d (Month,	Day, Year)
•	B		1000 U	1 pan	110	<i>9</i>		H	41	161	J	8/23	105	
	12		30. Name and andress of person w	o completed cause	of death (Item	23a) (Type,		<u> </u>	1.1-	_		/		nn-
- 24	()		31. Date filed (Month_Day_Year)	32. F	gistrar's Signa	UU ture	10	IAM	. ble	27		Ambe	1099	2,1110
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2. 4		Mus	H. L	back	,					V	

State of Maryland / Department of Health and Mental Hygien2005Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 15 PM ZOOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours | Min. 8. Date of Birth (Month, Day, Feb 23, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 2 M 2 □ F 79 578-34-3794 Washington DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, the Medical Exams and injury or othar traumatic event, the Medical Exams as I must be redified at 10a, State 10c. City, Town or Location 10d. Inside City Limits DC 1 Yes 2 No Director Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 26 16th St 20003 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur C. Yates Annise Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eliza C. Yates /Sister 26 16th St SE Washington DC 20003 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 12☐Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery 8-26-05 Washington Dc 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Home any ii 2617 Penn Ave SE Washington DC 20020 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arteriosc 250 resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical ast attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signad by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page ; certificate 1 🗆 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 \(\times \) Yes 2 \(\times \) No Be 26. Place of Death (Check only one, Hospital: Other: 1 🗌 Inpatient ٩ 3NT/OA 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swither R055 ashind

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 3 2005

P.O. Box 68760

				For State Registrar		State o	f Mary	yland		rtment of tificate o			-	giene Reg. No.	005	292	233
				1. Decedent's Name	e (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time o	f Death
		iysicia Medic	3 -	Bessie	Yancoı	ne							August	22	200	8:12	P.M
		camin				give street and nur				4b. City, Town	, or Location	of Death		4c. (County of Death	1	
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		neral ector		055-24-		1 ☐ M 2 🔀 F		73	Yrs.	Months Day		Min.	Manth 19	932"		place (State on intry) V York	Ji i Oleigii
				Usual Residence of	Decedent										TVC		
	arylan	To D	ڀ	10a. State	10b. County	6 3	10		Town or Lo	cation						10d. Inside C	tity Limits 2 ☐ No
	the Ma	ust be notified at	Director	MD		rford		Abe	rdeen	1.51.71.0.1				10 000	(111)		2 140
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٤	or Iten	irer	Fun	1 Never Marr	ied 2□ Marrie	Armed Fo	rces?			Vas Decedent of Yes, specify C			Rican, etc.)		Black, White		
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00	1215-0036 within 72 hours affer death with the Maryland one then "netural" or flems 23a or 28e-f show	dical	Completed	(Spec	15. Decedent' cify only highest	s Education t grade completed)			(Give	ent's Usual Oct kind of work do	ne durina mo	st of work	ing	16b. Kin	d of Business/I	ndustry	
8	within Feb.	I've M.	du	Elementary/Seco	ondary (0-12)	College (1	1-4or 5+)			oo NOT use ret vil Ser	,			II C	Govern	ment	
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10	ary shou and M	or other treumatic		19a. Informant's N	ame/Relationsh	ip (Type, Print)			19b. Mailin	g Address (Stre	et and Numb	er or Run	al Route Numb	er, City or	Town, State, Z	ip Code)	
0	2 = 2	er tre		Joseph	Yancone	e (Son)				Elizabe		, Abe	erdeen,	Mary	land 2	21001	
4	Ore, jes 1 al of Hea	r oth		20a. Method of Dis		3 Removal from		ren	netery cres	sition (Name of natory or other p	nlace)		Date - /OF		ation - City or T		
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	Baltim permit. Pag Department	any injury or o		21. Signature of Fu	ineral Service L	icensee NII (K	gele	sbe	22	Name and Add Tarrine Aberde	g-Carg	o Fur	neral H nd 210	ome, 01-33	P.A. 99		
				23a. Part1. Enter t shock, or hea	he disease, or our failure. List of	complications that conly one cause on e	aused the	e death.	Do not ent	er the mode of o	tying, such a	s cardiac	or respiratory a	rrest,		Approximation	tween
	Physi			Immediate Cause disease or condition	(Final on	- ARTZ	FRIO	SCL	ERC	TIC G	ARDIC	VAS	cula	2 D	15EASE	Onset and	Death
	/Med Exam			resulting in death)		Due to	(or as a co	onseque	nce of):								
		- 1	7	Sequentially list co	multions,	b. Due to	(or as a co	onseque	nce of):								
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2.1	P.O.		Ph			ns contributing to de	eath but n	not result	ing in the u	nderlying cause	given in Part	1.	23e. Did 1	obacco us	e contribute to	the cause of o	death?
, 0	dS, Fuires the	ed bl	d b	HYPER	TENS	101							1 🗆	Yes 2]No 3□Pro	bably 4 🖪	Unknown
55	Records, P.O. Box 68760, The law requires that the death certificate be executed the has been sinned by the attending physician and	N S	Completed by	CHROK		EWAL F	AIL	URI	<u> </u>				24a. Was		24b. Were aut prior to c death?	opsy findings ompletion of c	available ause of
因:						DIDISM							1 ☐ Yes	2 2 No	1 🗆 Yes	2 No	
	of Vital F Physicien: Th		Be	25. Was case reference examiner?		Hospital:			2/0				(Check only			4.1	
5			. To	27. Manufer of Dear		28a. Date (Mon	Inpatient of Injury		VOutpatien 8b. Time of	28c. lr	nury at		me 5∟Resi 28d. Describe		Other (Spec	ny)	
Ò.	Vision (Attending F r death.	e funer	atlor	1 ☑ Natural 2 ☐ Accident	5 Pending investig	9	th, Day Ye	ear)	Injury	V	Work? □Yes 2□	No					
0	Division or Attending after death. Director: After	by the	ifica	3 Suicide	6 ☐ Could n determi	ned 288. Place	of Injury	- At hom	ιe, farm, str	eet, lactory, office	ce		281. Location (City or To		Number or Ru	ral Route Num	iber,
ancon	Div tel or A	ni be	Certification	T													
\succ	DIVISION To the Hospitel or Attention 24 hours after deaff	efely fill	Medical	29a. Certifier (Check only one)		g Physician: To the Examiner: On the b and man		aminatio									s)
	To the within 2	фшо	Me	29b. Signature and	title of certifier					29c. Lio	ense number			29d. Date	signed (Month	, Day, Year)	
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	<i>U</i> .1.*	Sta	te	31. Date filed (Mor	nth, Day, Year)	32. F	Regisar's	Signatu	re								
	R	egistr	ar		AUG 2	4 2005	Blue	w	J.	Speeds							

State of Maryland / Department of Health and Mental Hygiene 2005 29234 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 08/19/2005 2:58 P^{M} Dorothy Ruth Zebro /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year 08/18/1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖫 F 82 Massachusetts 033-14-0699 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural, or Items 23e or 28e-1 show ury or other traumetic event, the Medical Examinating the notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1X Yes 2 □ No Director Maryland Prince Georges Bowie 10g. Citizen of What Country? 10f. Zîp Code 10e. Street and Number 20715 USA 3710 Ivy Hill Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Warwick School Elementary/Secondary (0-12) College (1-4or 5+) Department Business Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mable Olsen Frank Olsen မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3710 Ivy Hill Lane Bowie, MD 20715 Dorothy V. Coit/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rhode Island 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H
Important: If Ite
any injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □ Donation 5 □ Other (Specify) 08/25/2005 Exeter, Rhode Island Veterans Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Sc 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COROWARY Aateru **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** hyperlipidemin Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examiner attending physicien and for use as the burial-transit that the death certificate be executed Due to (or as a c sequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ pe 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No certificate 1 ☐ Yes 2 No 1 Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 🔲 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Magner of Death 28b. Time of 28c. Injury at Work? Certification; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061704 100 let d cause of death Item 23a) (Type, Print) 30. Name and address of person who co MARK W.D. 9101 Cherry Lane Suite 205 Laurel, MD 20708 DIVIER 37 Registrar's Signature 31. Date filed (Month, Day, Year)

AUG 2 2 2005 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 30 Day 2005 ear **Physician** Mabel Louise Zentmyer 3:40A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Coffman Nursing Home Hagerstown If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1 □ M 2√□ F Hours 92 Director Oct. 8, 1913 Maryland 214-09-7082 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County or 28a-f show njury or other traumatic event. The Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "neturel", or Itams 23a USA 21740 Funeral 340 Pangborn Blvd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auditor Retail 12 permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harriett Hawk Harry Zentmyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 842 Summit Ave. Hagerstown MD 21740 Sandra Blair/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SEpt 9 2005 Hagerstown MD Rest Haven Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral chapel 1601 Pennsylvania Ave Hagerstown MD 21742 5 Mull 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the gode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Lucute Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) VAME FOUND TO PHYSICIAN -Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months.
1 Yes 2 No Day Year 5 Other (specify) ector, page 2 should be detached the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 4 100 1 ☐ Yes 2 ☐ No of or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 completely filled in by the funeral air 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? .27. Manne of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 🗆 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funeral L Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

samue 31. Date filed (Month, Day, Year)

LOUISE ZENTMYER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Locus

7 2005

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M		1 - For Unpend Item	State of N 23a,27,2	Maryland / Dep 8a-f per æg	artment of I C848 10- rtilicate of	lealth and 6-05 tas	Mental Hyg	giene 109. No.2 0 0 5	29236
		Decedent's Name (First, Middle, La					2. Date of Dea	th	3. Time of Death
Physic /Med		BARBARA MONROE	ALEXANDER	₹			Septembe	er 5 2005	2303 M
Exami		4a. Facility Name (If not institution, gi				or Location of Dea		4c. County of Dea	ath
		601 Cornell Stre			Aberdee			Harford	
Funera Director		217-38-8446	Sex 7.7 1 ☐ M 2 🔯 F	Age (In yrs. last birthday 62 Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day	Year) C	rthplace (State or Foreign ountry) MARYLAND
9 mand		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
Many	to	MD HARFO	SD.	ABER	EEN				1 ☐ Yes 2 🖾 No
death with the Maryland ms 23e or 28e-f show rmust be notified at	Director	10e. Street and Number	(D	113210	10f. Zip Code		1	10g. Citizen of What C	ountry?
th with	al D	601 CORNELL STREE	ET APT#200)	2100	1		U.S.A.	
` ≥ 8	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	Ø No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- rto Rican, etc.)	C'4	
Phou stura	ed t	15. Decedent's 8	ducation	16a. Dec	edent's Usual Occup	pation		16b. Kind of Business	
Maryland 21215-0036 d 2 should be filed within 72 hours att th and Mental Hygiene. It is marked other then "natural", or traumatic event, the Madical Exertite	Completed	(Specify only highest given the secondary (0-12) 1 2 th	ade completed) College (1-40	(Giv	e kind of work done DO NOT use retire PAINTER	during most of wo	orking	BETHELHAM	•
Hyginethert, ant,	BeC	17. Father's Name (First, Middle, Las				18. Mother's Na	ame (First, Middle,		
land be tental riked or	To B	SYLVESTER GRENNE				GLADYS	S. ALEXA	ANDER	
and N	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ing Address (Street	and Number or F	Rural Route Number	r, City or Town, State,	Zip Code)
and 2 auth n 27 l		DON ALEXANDER/ SO	ON		BOX. 837	Perryvi	lle, MD_	21903	
of He		20a. Method of Disposition 1X□ Burial 2 □ Cremation 3	Removal from Stat	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	сө)	Date	20c. Location - City of	r Town, State
imor Pages ment of I tant: If it	١.,	4 Donation 5 Other (Spec	ify)	BERKLEY			0-2005	DARLINGTO	·
Baltimore, permit. Pages 1 at Department of Hea Important: If Item eny Injury or othe		21. Signature of Fundal Service Lige	en see						m. F/H-Harfo een, MD 21001
Physician // Medical Examiner be executed physician and the prinal-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or t	as a consequence of): as a consequence of): as a consequence of):					
I Records, P.O. Box 68 The law requires that the death certification has been signed by the attending pipage 2 should be detached for use as it.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year
cords, P	ed by P	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	ven in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
Vital Records, sician: The law requires t certificate has been signe rector, page 2 should be to	Completed			·			24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of s 2 No
Vital Ician: T	Be	25. Was case referred to medical examiner?	Hospital:		10		eath (Check only or	10)	
on of Vital	on: To	1 □ Yes 2 □ No 27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Ir	pjury 28b. Time	of 28c. Inju	y at rk?		ence 6 Dether (Spe ow injury occurred	unk
ivision or Attendation de by the	Certification:	2 Accident investigation 3 Suicide 6 Could not determined	28e. Place of building,	Injury - At home, farm, s etc. (Specity)	L D'''	Yes 2X No	28f. Location (Si City or Town	treet and Number or R n, State) 601 Co	rnell Street
To the Hospital owithin 24 hours at To the Funeral D completely filled is	Medical Ce	(Check only 2 Medical Exa	hysician: To the be	at home st of my knowledge, dea of examination and/or i	th occurred at the ti	me, date and place	e, and due to the c	erdeen, Ma ause(s) and manner a late and place, and du	s stated.
thin 2 the other	Med	29b. Signature and title of certifier	and manner	SIAIBO.	29c. Licens			9d. Date signed (Mon	
F.≱F. 8	1	1.10	2 2 . /	7410					
		30. Name and address of person who	1		, Print)	ME Street		eptember,	
Si Regis	ate	31. Date filed (Month, Day, Year) SEP 0 8 201	#. Regis	strar's Signature		em Stree	et Baltii	more, Mary	Land 21201
ricgis		JL1 0 0 E0	Les Marion						

AEM 05-05821

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Physicia	an	Decedent's Name (First, Middle, Last) Harry G. Alexander					2. Date of Death	29°, 2005°°	3. Time of Death 6:29 PM
/Medic Examin		4a. Facility Name (If not institution, give structure) Union Memorial				or Location of Death		4c. County of Death	0.25
Funeral Director	Ī	216-92-5725	7. Age	(In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y. 03-16-1965	9. Birthp Cour Maryla	place (State or Foreign end
death with the Maryland ms 23a or 28a-1 chow I must be redified at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			1	0d. Inside City Limits
any injury or other treumatic event, it a Medical Evanirat must be retified at 906s.	ctor	MD NA			Baltimore				1XXYes 2 □ No
	Funeral Director	10e. Street and Number			10f. Zip Code			. Citizen of What Cour	ntry?
	erai	1921 Homewood Avenue	2. Was Decedent E	ver in U.S.	21218	Hispanic Origin? (Spe	USA	14. Race - Americ	an Indian.
	β	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 2 No		Rican, etc.)	Black, White, Specify: Black	etc.
	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	16a. E	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	oation during most of workii	ng 16	o. Kind of Business/Inc	
	ошо	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ire. DO NOT use retire: Intainance	d)		Healthcar	re
	To Be C	17. Father's Name (First, Middle, Last) Milo Alexander				18. Mother's Name	(First, Middle, Ma.	den Sumame)	
	i	19a. Informant's Name/Relationship (Type		19b. I	Mailing Address (Street	and Number or Rura	l Route Number, C	ity or Town, State, Zip	Code)
		Barbara Alexander/Moth	er		5 E. 43rd Stre			. Location - City or To	um Stato
		1 X Burial 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		disposition (Name of crematory or other place Cemetery	^{сө)} 09–07⋅		ltimore, MD	wn, State
		21. Signature of Funeral Service Licensee		70011011	22. Name and Addre				
		23a. Part1. Enter the disease or complica shock, or heart failure. List only one	2					mor St. Balte	o, MD 21217
	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and leading to an additional season of the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to for as a	Intoxic consequence of consequence of					Onset and Death
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	e. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	y		23d. Date of delive Month	ry Day Year
	Ď	Part II. Other significant conditions contr	ibuting to death bul	t not resulting in t	ne underlying cause giv	ren in Part I.		co use contribute to th	e cause of death? ably 4 □Unknown
A STATE OF THE PERSON OF THE P	Completed						24a. Was an autopsy performed	pnor to cor death?	osy findings available inpletion of cause of
	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatien	t 2 🗆 ER/Outp	atient 3 TOOA Oth	26. Place of Death		e 6 ⊡Other (Specify	
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury Found 8-29-05	28h Tin	ne of 28c. Injur	y at 2	8d. Describe how i		-
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Found at	Reside		Ba	altimore,	Maryland	Route Number. lewood Ave.
- 1	Medical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	r: On the best of r: On the basis of and manner state	examination and/	death occurred at the time or investigation, in my o	me, date and place, a prinion, death occurre	nd due to the caus ed at the time, date	e(s) and manner as stand due to	ated. the cause(s)
	ã							_	
	Me	29b. Signature and title of certifier	10		29c. Licens	e number	29d.	Date signed (Month, I	Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

cian	n	 Decedent's Name (First, Middle, I Stephen Edward 		n				Augu		Day 31	Year 2005	1851	D04((1)
dical iner		4a. Facility Name (If not institution, g	give street and nu	ımber)		4b. City, Town,	or Location of	-	IS L		ty of Death	10)1	
		Upper Chesapeake	e Medica	1 Center	<u> </u>	Bel A				Harf	ford		
al	1	5. Social Security Number 6. 219-86-8859	.Sex 1 <mark>D</mark> M 2 □ F	7. Age (In yrs. 37	last birthday) Yrs.	Months Days		Min. (Moi	of Birth oth, Day, Y		9. Birthp Coun	place (State or htry)	Fore
r	-	Usual Residence of Decedent	A	37				Apri	1 3,	1968	Mary	land	
		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside Cit	y Lim
Director	25	Md. Cecil	<u> </u>		Ris	sing Sun						1 🗆 Yes	2 🙀
		10e. Street and Number 23 Ailsa Court				10f. Zip Code	21911		10g		5.A.	ntry?	
Funeral	e a	11, Marital Status	12. Was Dec	edent Ever in U	.S. 13.			n? (Specify Ye	s or No-		ce - Americ	an Indian	
		1 Never Married 2 Married	Armed Fo	orces?		Was Decedent of If Yes, specify Cul		Puerto Rican, e	itc.)		ack, White,		
	2	3 Widowed 4 Divorced	Year or E	Dates:		1 ☐ Yes 2 No	Specify:			Speci	ify:		
100	Сотріете	15. Decedent's (Specify only highest of	grade completed))	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	ipation during most o	of working	16	8b. Kind of I	Business/Inc	dustry	
8	E	Elementary/Secondary (0-12)	3 College (1-4or 5+)	teacl		ea)		ра	arochi	ial sc	:hoo1	
1	a l	17. Father's Name (First, Middle, La	ist)				18. Mother's	s Name (First,					
α	0	Richard Brotzma	an				Ann S	atterfi	leld				
ľ	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Stree	and Number	or Rural Route	Number, C	City or Town	n, State, Zip	Code)	
		Jennifer T. Bro	otzman/w		_	Ailsa Co			-				
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	State 20b. P	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20	c. Location	- City or To	wn, State	
		4 Donation 5 Other (Spe		Bay		Cremator		2/2005	I	Baltin	nore,	Md.	
		21. Signature of Funeral Service Lic	censee	->	2	2. Name and Addr Schimune	ess of Facility k Funer	al Home	e of I	Bel A	ir, In	nc.	
						6 1 A T.I M	o o Dhoril				Md 21	() 4	
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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if tiem 27 is marked other than "natural", or tiems 23a or 28a-f show any injury or other traumatic event, I'm Mudical Evarual or invalled recitifical and once.

To Be Completed by Funeral Director

29a. Certifier (Check only one)

Physician

/Medical

Examiner

Funeral

Director

tor use as the burial-transit

physician

Pleas	se Type or Pri	nt in Blac	k Ind	lelible In	k. Ensu	ıre Al	l Copies A	re Legi	ble.	
1 - For State Registrar	State of M	aryland / [Оера	rtment of tificate o	Health a	and M	lental Hygi	ene2 0	05	29239
1. Decedent's Name (First, Middle,	, Last)						2. Date of Death Month	Day	Year	3. Time of Death
James Anthor	ny Butt						SEPTEME		2005	07:08 AM
4a. Facility Name (If not institution,	give street and number)			4b. City, Town	, or Location of	of Death	<u>-</u>	4c. County	of Death	
VA MARYLAND HEA					PERRY				CEC	IL
5. Social Security Number 217-12-6142		je (In yrs. last bir 81	thday) Yrs.	If Under 1 Year Months Day		Min.	8. Date of Birth (Month, Day, June 13,	Year)	Cou	place (State or Foreign
Usual Residence of Decedent	^	01					June 13,	1924	Mari	yland
10a. State 10b. County		10c. City, Tow	n or Loc	ation					1	Od. Inside City Limits
Maryland Balt	imore		٨	lotting	ham					1 ☐ Yes 2 No
10e. Street and Number				10f. Zip Code			10	g. Citizen of \	What Cou	ntry?
4712 Beacons	field Drive				21236			u.s.	.A.	
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent o	f Hispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)			an Indian,
1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced		No		Yes 2 N		, 1 40110	riodii, etc.)		ck, White, v: Whi	
15. Decedent's	s Education	16a.	Decede	ent's Usual Occ and of work dor	cupation	t of worki	1	6b. Kind of B	usiness/In	dustry
Elementary/Secondary (0-12)	College (1-4or		irre. D	O NOT use reti	red)	. OI WOFKI				
6th Grade			Car	ipenter	-					ntractor
17. Father's Name (First, Middle, L							(First, Middle, Ma	aiden Surnan	10)	
	utt				Anı		Grabus			
19a. Informant's Name/Relationsh Mrs. Irene E. I							Poute Number, Ve, Notte			
20a. Method of Disposition				ition (Name of	Jocetu			Oc. Location -		
1 XBurial 2 Cremation		cemete	ry, crem	atory or other p		1710			-	
4 □ Donation 5 □ Other (Sp21. Signature of Funeral Service L		PWIRW		Cemete		1/1/2	2005 Bo imunek Fu	utumo?	Le, M	arykand .
> Stefano	e Rina	Der	9	705 Be	lair Ro	d., E	Baltimore	, MD	2123	
23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused only one cause on each li	d the death. Do i	not ente	r the mode of d	ying, such as	cardiac o	r respiratory arres	st,		Approximate Interval Between
Immediate Cause (Final disease or condition	CHRONI	C OBSTR	UCTI	VE PULN	ONARY	DISE	ASE		ι	Onset and Death JNKNOWN
resulting in death)	-	a consequence								
Sequentially list conditions .	0.	RESPIRA'		FAILUE	RE					
if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							
Cause (Disease or injury that initiated events resulting in death) Last	c		-6)						-TAV	
and the second s	Due to (or as	a consequence	or):							
· ·	d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		Ectopic pregnar Other (specify)				23d. Dai Mo	te of delive	ery Day Year
Part II. Other significant condition	ns contributing to death t	out not resulting in	n the un	derlying cause	given in Part I.		23e. Did toba	cco use cont	ribute to th	ne cause of death?
										ably 4 XUnknown
							24a. Was an	24b. \	Vere auto	psy findings available mpletion of cause of
							autopsy performe 1 Yes 2	ed?	prior to co death? I □ Yes	
25. Was case referred to medical					26 Place	of Death	1 Yes 25		i ∐ tes	ZLI NO
examiner? 1 ☐ Yes 2 X No	Hospital:	ent 2□ER/Ou	utpatient	3 DOA	Other.		ne 5 Residen		er (Specif	v)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	28a. Date of Inju (Month, Da	ury 28b.	Time of njury	28c. In		2	28d. Describe how			
3 Suicide 6 Could not determine	ot be 28e. Place of In	jury - At home, fa tc. (Specify)	ırm, stre				28f. Location (Stre City or Town,	et and Numb State)	er or Rura	I Route Number,

To the Hospital or Attending Physician: The law requires that the death certiticate be executed Division of Vital Records, P.O. Box 68760, neral Director; Atter this certificate has been signed by the: filled in by the funeral director, page 2 should be detached within 24 hours after death. To the Funeral Director; After

Medical Certification: To Be Completed by Physician/Medical Examiner

any 30. Name and address of person who Impleted cause of death (Item 23a) (Type, Print) VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

JIANYI ZHANG, M.D., 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SEP 0 8 2005

32. Registrar's Signature

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

VA01010581201

29d. Date signed (Month, Day, Year)

SEPTEMBER 3, 2005

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene, 29240 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 4, **Physician** 8:10 P M Bonomolo Vincent /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey House N/A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) April 25, 1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1**X** M 2□ F Maryland Yrs. 215-24-8325 76 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 23e-f show any injury or other traumatic event, the Medical Exercit artificial at 1 ☐ Yes 2 No Maryland Baltimore Director Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 U.S.A. 212 Aigburth Avenue, Apt. 204 Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painting Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yolanda Andrew Bonomolo DeManss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Jo Nelson (daughter) 1225 Conowingo Rd., P.O. Box 37, Bel Air, MD 21014 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore. Maryland 9/8/2005 Bayview Crematory ¹ 4 □ Donation 5 □ Other (Specify) Schimunek Funeral Home of Bel Air, Inc 610 W. MacPhail Rd., Bel Air, MD 21014 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) cancer **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death

To the Funerel Director:
completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and Alls of certifier September 6, 2005 (80 MD) DZ4170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. TSOWD Richey Hospice \$38 N EutawSt Baltimore MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 1- State State AMEND ITEM #20b Per FH G847 9/08/10\(\) to Use to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Amend Item #20b Per FH G847 9/08/10\(\) to Use the State of Mary and Mary a 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) OS **Physician** 0456 M 31 OWA KO P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore ummo Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1**△**M 2□ F 213-26-3813 Yrs. MARCH 2, 1930 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow other treumatic event, the Medical Exeminer must be notified at 1 ☑ Yes 2 ☐ No Director MARYLAND 28a-f 10g. ditizen of What Country? 10e. Street and Number ō 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or Items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Item any injury or other treumatic event, the Medical Exercities. 1 ØYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) STATE OF MARY 4STODIAN UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) COLOSPRING LANE APT F BALTO, HD 21215

20c. Location - City or Town, State SANDRA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State OWINGS MILLS, MD. FOREST 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of AVE, BALTO, MO. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSI Physician Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last The law requires that the death certificate be exec Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ρ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 XInpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within 2 29c. License number / 580 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of who comple d cause of death (Item 23a) (Type, Print) 10N UNIVERSITY State Registrar SEP 0 8 2005

Baltimore, Maryland 21215-0036

		Registrar 1. Decedent's Name					Dealli	2. Date of Dea	giene 005	3. Time of Death
Physic /Medi		MILDE	RED BLA	CKWELL				SEPTEMB		0912 Ам
Exami	ner		not institution, give s	treet and number)			n, or Location of Deal	th	4c. County of Deat	h
Funeral Director		5810 GIST 5. Social Security Nu 219–88–6	mber 6. Sex	M 2√∏ F 7. Age	(In yrs. last birtho	Months Da			h 9. Birt	hplace (State or Foreign untry) RYLAND
and and		Usual Residence of I	Decedent 10b. County		10c. City, Town o	or Location				10d. Inside City Limits
Maryi	tor	MD	N/A		BAL	TIMORE (CITY			1 X Yes 2 □ No
or 284	Director	10e. Street and Num				10f. Zip Cod			10g. Citizen of What Co	untry?
eath w	Funerai	4005 BA	ATEMAN A	VENUE 2. Was Decedent E	ver in U.S.	212	2 1 6 of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - Ame	rican Indian.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or items 23e or 28e-f show simportant: if Item 27 is marked other then "natural", or items 23e or 28e-f show ship Injury or other traumatic event, Ite Medical Exam an invalie or ceilified at SINE.	þ	Never Marrie 3 Widowed 4	ed 2 Married	Armed Forces? 1 ☐ Yes XIXN If Yes, Give Year or Dates:		If Yes, specify C	luban, Mexican, Puer	to Rican, etc.)	Black, White	
"natur	eted	(Specil	15. Decedent's Educ fy only highest grade	ation completed)	(6	ecedent's Usual Oc Give kind of work do fe. DO NOT use re	ne during most of wo	orking	16b. Kind of Business/	•
iene.	Completed	Elementary/Secon	· · · · · · · · · · · · · · · · · · ·	College (1-4or 5- YEARS	+)	UNSELOR	urea)		BON SECO	
al Hyg	BeC	17. Father's Name (F	First, Middle, Last)		, ,	0.110111011		me (First, Middle,	•	
Ment Marked Marked Marked	5	WILL		CKWELL	405.4	A. II	VERNA		FFIN	T. 0-41
od 2 st Ith and 27 is n r traun			me/Relationship <i>(Typ</i> R. WHITE			•	N ANNE RI		r, City or Town, State, Z TIMORE, M	D 21216
of Hea		20a. Method of Dispo			20b. Place of D	isposition (Name of crematory or other	place)	Date	20c. Location - City or	
Pag tment tent: I		4 Donation	5 Other (Specify)		LORRA	INE PK.		13/05	BALTIMOR	E CO. MD
Deparition Department of the service		21. Signature of Fun	neral Service License	X X	171	22. Name and Ad				OME 21207
		23a/Port. Enter the	disease, or complice failure. List only on-	ations that caused e cause on each lin	the death. Do not				AVE., BAL rest,	Approximate Interval Between
Physician		Immediate Cause (F	Final	Asphyxia	-					Onset and Death
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that the death certificate to the by the attending physic detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☑ Onknown	months?	3c. If yes, outcome of 1□Live birth 3c. 4□Pregnant at 9□Unknown	2 □Fetal death	3 ☐Ectopic pregna 5 ☐ Other (specify			23d. Date of del Month	ivery Day Year
E Q E	by Ph	Part II. Other signific	cant conditions con	Inbuting to death bu	it not resulting in th	ne underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
s tha		l .							'es 2.XXNo 3.∏Pr	obably 4 Unknown
equires tha sen signed rould be del	ted							1 O Y		
: The law requires tha cete has been signed , page 2 should be de	Completed							24a. Was a autop	an 24b. Were au	topsy findings available completion of cause of
sicien: The law requires tha certificete has been signed irector, page 2 should be de	Be Completed	25. Was case referre examiner?	H	ospital:	2 58/Outo	ation: 2 DOA	0.1	24a. Was a autop perfor 12 Yes	an 24b. Were au prior to death? 2 \(\triangle	2 □ No
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DHMH 17 Rev 1/2001

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

			For State Registrar		State of Mar		epartment of he Dertificate of		d Mental Hygi	ene2005	5 29243
		*	Decedent's Name (F	irst, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Virginia	Bishop					Algust	27, 200°	0 - 1 - 14
4	Examin	~ .	4a. Facility Name (If no	t institution, give	street and number)		4b. City, Town, o	or Location of De	eath J	4c. County of De	eath
			Maryjar	id Gener			day) If Under 1 Year	nore (ity		(2)
	Funeral Director		5. Social Security Number 214-20-71		M 2C F 9	(In yrs. last birth	Months Days	If Under 24 Hours M	Irs. 8 Date of Birth (Month, Day, 2/2/19	9. E 10 M	Birthplace (State or Foreign Country) ARYLAND
	land ow		10a. State 10	b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary e-f sh	tor	MD I	I/A		BALTIM	ORE				1 Yes 2 No
	or 284	Director	10e. Street and Number	r			10f. Zip Code		10 II.	g. Citizen of What S OF A	Country?
	23g		1912 Herk	ert St			2121				
396	be filed within 72 hours after death with the Maryland Hygiene. And Hygiene. ad they filen. And the then "neturel", or items 23s or 28e-f show other then "neturel", or items 23s or 28e-f show event, the Madical Evanitar must be notified.	by Funeral	11. Marital Status1 ☐ Never Married3 ☐ Widowed 4 ☐	_	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		 Was Decedent of I If Yes, specify Cub Yes 2 No 		(Specify Yes or No- lerto Rican, etc.)	14. Race - Al Black, W Specify:	
2-0	72 hou	ted	15 (Specify	. Decedent's Edu only highest grad	ication	16a. C	ecedent's Usual Occu Give kind of work done	pation	working 1	6b. Kind of Busine	ss/Industry
21	within 7 ene. then "r	Completed	Elementary/Seconda		College (1-4or 5+)		ife. DO NOT use retire	d)	WOIKING		
21	e filed within al Hygiene. i other then '		N?A 17. Father's Name (Fire	-4 44444 14	N/A	H	OUSE KEEP		Name (First, Middle, M		FAMILIES
Maryland 21215-0036	2 should be fi and Mental H is marked ot eumatic ever	To Be	ED DOTS		EASED)					(DECEAS)	ED)
-	nd 2 shutth and 27 is m		19a. Informant's Name GERALDINE						Rural Route Number, TREET BA		
altimore	Pages 1 ar		20a. Method of Dispos 1 ☐ Burial 2 ☐ 4 ☐ Donation 5 [ETAME!	Removal from State	METRO	Disposition (Name of CREMATOR	Ŷ 9/1		oc. Location - City ATONS VI.	or Town, State LLE, MARYLAND
Balti	permit. Pages i Department of H Importent: If ite eny injury or ot		21. Signature of the	al Service Licens	WIS T. G		I a second		FUNERAL I		
r	1.0		23a. Part1. Enter the c	disease, or comp	lications that caused the	ne death. Do no	4517 PARK t enter the mode of dyi	ng, such as card	ITS AVENUI diac or respiratory arre	E BALTO	Approximate Interval Between
	Priysician /Medical		Immediate Cause (Fin disease or condition resulting in death)		Aspira	consequence of	neumonia	a			Onset and Death
ľ	Examiner	J.	Sequentially list condit	ions,	cereb		war Ac	w dent			
V	nted Insit	Examine	if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ng Iry	HUOST	tons	00				
Ŏ,	be executed Iclan and burial-transi	Еха	that initiated events resulting in death) Las	t I	Due to (or as a	consequence of):				
68760	cate phys the	dical		ſ	o. Diabe	tes n	ne 11:tus				
Box	death certifica e attending ph ed for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 Yes 2 N	nths?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	у		23d. Date of a	delivery Day Year
P.0	that the de ed by the detached	Phys	9 Unknown								
	sign d be	by	Part II. Other significa	nt conditions co	hronic (not resulting in t	he underlying cause gr	ven in Part I.			e to the cause of death? Probably 4 ① Onknown
Vital Records,	elaw has b je 2 s	Completed						-	24a. Was an autopsy perform	ed? prior t	autopsy findings available to completion of cause of ?
/ita	icien: Th certificate rector, pag	Be (25. Was case referred examiner?	_					Death (Check only one		
of \	Physicien: this certific ral director,	2	1 Yes 2 No		Hospital:		atient 3 DOA	ner: 4 ☐ Nursin	g Home 5 Resider		pecify)
o uc		lon:		5 ☐ Pending	28a. Date of Injury (Month, Day		ury Wo	ryat rk?]Yes 2∐No	28d. Describe how	v injury occurred	
Division	ten leat tor: the	Certification:	2 Accident 3 Suicide 4 Homicide	investigation Could not be determined	28e. Place of Injur building, etc.	y - At home, farr (Specify)	n, street, factory, office	1.63 2	28f. Location (Str. City or Town,		Rural Route Number,
	Hospitel 4 hours Funerel ely filled	ledicai Ce				xamination and			ace, and due to the car courred at the time, da		
	To the within 2 To the complet	Me	29b. Signature and title	e of certifier			29c. Licen	se number	29	d. Date signed (Mo	onth, Day, Year)
			1	7 "	7 2		8	9529	9 6	August 2	7.2005
	9		30. Name and address			ath (Item 23a) (T				Jus, a	1,000
	7			ADHAVA			NDEN AV	ENVEI	BALTIM	ore m	D 21261
	Sta Registr		31. Date filed (Month,		32. Redistrar	's Signature	Coaste				

			. 101	partment of Health and Me ertificate of Death	ental Hygier Reg. t	711115	29244
	9 7		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Yeer	3. Time of Death
	Physicia /Medic		Ida Lillian			7, 2005	11:45 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	'	4c. County of Death	
			8 Broadship Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Dundalk V) If Under 1 Year If Under 24 Hrs.	B. Date of Birth	Baltimore	ace (State or Foreign
-	Funeral Director		214-03-2592 1 M 2 XF 90 Yrs.	Months Days Hours Min.	(Month, Day, Yea Soruary 9,1	ar) Coun	try)
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or				Od. Inside City Limits
	fanyla show	ŏ	MD. Baltimore Dunc			1"	1 ☐ Yes 2 🛂 No
	the N 28e-f	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Coun	try?
	h with	iO is	8 Broadship Road	21222		USA	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - America Black, White, 6	
36	s after , or Ita	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [X] No If Yes. Give	1 ☐ Yes 2 ☑ No Specify:	,,	Specify: Whit	
Ö	filed within 72 hours after death with the Maryland Hygiene. ther then naturel', or Items 23e or 28e-f show ant, the Madical Examiner must be notified at		3 XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	16b	. Kind of Business/Inc	
7	in 72 in "ne Medic	Completed	(Specify only highest grade completed) (Gi	ve kind of work done during most of working . DO NOT use retired)	3		
21,	er the	Com		ousewife	Ov	vn Home	
pu	be file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (en Sumame)	
Maryland 21215-0036	d Men narke	2	George Magnus Pitz 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Mary Mor		una Toura Ctata Zin	Cadal
Ma	d 2 st th and th and treur			roadship Road, Dunda		y or 10wn, State, Zip 1222	Code)
ē,	is 1 and 2. If Health ar item 27 Is other tree		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place) Septem		Location - City or To-	wn, State
E	Page: sent o nt; If iry or		1 🔀 Burial 2 🖂 Cremation 3 🖂 Hemoval from State	Cemetery 10, 20		ndalk, MD.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then. Insturel; or items 23e or 28e-f show any injury or other treumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Connelly Funeral Ho 7110 Sollers Point	me Of Dur	ndalk,P.A.	21222
	=		23a. Part 1. Enter the disease, or complications that caused the death, do not shock, or heart failure. List only one cause on each line.			Idain, IID.	Approximate
	Pnysician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	1 / 1			z year
	Examiner		Sequentially list conditions, b. Congo Cun's	earl failing			1 year
7	ed isit	ine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	-21- W			20
V	xecut and	Examiner	that initiated events resulting in death) Last C. Due to (or a vonsequence of):	250			2) years
8760,	cate be executed physician and the burial-transit	dicai E	d.				U
9	tificat ng phy as th	ledi					
Вох	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months? □ The past 12 months?	B Ectopic pregnancy		23d. Date of delive Month	ry Day Year
0.	the at	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		Worter	Day Tour
Q	es that the de gned by the a be detached t	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death2
Records,	urres ngo ld be	d by			1 🗆 Yes	2 □ No 3 □ Proba	ably 4 DUnknown
CO	> 00	Completed			24a. Was an	24b. Were autor	sy findings available
Re	The lav	om			autopsy performed? 1 Yes 2 4	?/ death?	ipletion of cause of
Vital	ysicien: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?	26. Place of Death			
of V	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			6 ☐Other (Specify)
ou c	Jing P	lon	27. Manner Death 1 Matural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)		3d. Describe how in	njury occurred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined continuous at the continuous and the continuous attention attention and the continuous attention a		3f. Location (Street	and Number or Rural	Route Number,
Ω	after Dire	Certification:	4 Homicide building, etc. (Specify)	,,	City or Town, Sta	ate)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Check only Check only Medical Exeminar: To the best of my knowledge, de	ath occurred at the time, date and place, ar	d due to the cause	(s) and manner as sta	ated.
	the H hin 24 the F nplete	l edical	one) and manner stated.				``
	With To	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, I	Jay, Year)
7	-		30 Name of addition of a fact that the state of the state	0/77 <u>1</u> 7)	0 1.	1/4/03	
	3		30. Name and advisess of person who completed dause endeath (Item 23a) (Typ	e, Print)	Salt /	11/2/2	22
• 4	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	1		·V	
14	Registr	ar	SEP 0 8 2005 See St 19	porte			

 $^{9.847}$ $^{9.78}$ $^{7.8}$ amend 25,27 per Dr. State of Maryland / Department of Health and Mental Hygieng Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Baby Girl Broadnax Twin A -08:49A February 26 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOPKIN tosptia Soffm If Under 1 Year | If U 1 tus JOHNES If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrg. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🗓 F Yrs Director none 26, Maryland Usual Residence of Decedent with the Maryland 10b County 10a State 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at MD Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2710 Pelham Avenue 21213 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examina ans. 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Baker Michele Broadnax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 X Other (Specify) in state Signatur of Euneral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street director. Baltimore, MĎ 21201 nicelo Rant1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, feeding to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of, The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 🔀 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 ⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anthin

State Registrar 31 Date filed (Month, Day, Year)

32. Registrar's Signature

Marta Worke St.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

9/8/05 KBH amend 9 per A.B. g851 1/19/06 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 24,27 per Dr. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 29246 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Baby Boy Black 06 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore HOPKINS Johns If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, May 330 **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F Months Days 7 Director Yrs. none 2005 May Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exercise or restricted at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1√ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2242 Cedley Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk Regina Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ▼Other (Specify) in state 21. Signature of Euneral Service License Ronald Range 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate causa. Enter understand Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical jo detached cate has been signed page 2 should be det ၉ After this Medical Certification: within 24 hours after death To the Funeral Director: , completely filled in by the f

the

à

certificate

Pis

IF FEMALE:

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de

9 Unknown

ncy death ath	3 ☐ Ectopic pregnancy
alli	3 □ Other (specify) _

23d. Date of delivery Month Day

9 Unknown	9□ Unknown
Part II. Other significant condition	is contributing to death but not resulting in the underlying cause given in Part \mathcal{H}

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an

Year

5. Was case referred to medical					26
examiner? 1 ☐ Yes 2 No	Hospital:	Ippatient	2 ER/Outpatient	3□ DOA	Other:

28a. Date of Injury (Month, Day Year)

 Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 ☒ No autopsy performed? 2X No 1 ☐ Yes . Place of Death (Check only one)

	case refer	red to me	edical
exam		/	
1 □ Y	'es 2 🗙	No	
	-	_	
27. Mann	er of Doat	h	

28b. Time of 28c. Injury at Work? М 1 ☐ Yes 2 ☐ No

g Home	5 🗆 Res	idend	e 6	□Other	(Specify
28d.	Describe	how	injury	occurred	1

1X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier	
	(Check only	
	one)	

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D0060780 29d. Date signed (Month, Day, Year)

30. Name and address of pers in who complete feuse of death (Item 23a) (Type, Print)

June 06,2005

State Registrar

600 N. Wolfe Street Baltimore, MD Carolyn Boylan, MD 31. Date filed (Month, Day Year) 8 200 532. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 29248 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2005 ANGUST /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JAG Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 10M 20F Months Days Hours Yrs. WEST VIRGINIA Director Usual Residence of Decedent 10d. Inside Çity Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show the Medical Examinar must be notified at 1 Nes 2 No Director 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a NITE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) IANAGER 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, permit. Pages 1 and 2 is Department of Health ar Important: If item 27 is any injury or other trau QDICS. SILVER SPRING, MD 2090 ERRY BOYL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State ANATOMY GIFTS REG. 8/31 HANOVER, MD 5 ☐ Other (Specify) Fral Se 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part1. Enter the disease of complications that passed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one control of the cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GLIOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-tran Due to (or as a consequence of) Box 68760, the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2000 the Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 20No 1 Tyes 3□ DOA Medical Certification: To this Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6420 ROCKLEDGE 5 And Boccis 31. Date filed (Month, Day, Year) SEP 0 8 2005 32. Restrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 5 29249 1 - For State Registres Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BALLARD RICHARD **Physician** 1:33 PM SEPTEMBER 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE, MARYLAND N/A If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 25,1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** West Virginia 1**X** M 2□ F 84 236 26 2589 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits nant: If item 27 is marked other than "natural", or items 23s or 28a-f show injury or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Linthicum Heights the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S. 27 Colonial Drive 21090 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status hours after 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry perrit. Pages 1 and 2 should be filed within 72 h Dep. riment of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, Ite Modica once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lost Control Rep. Signa Insurance Co. 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lena L. Loudermilk E. Don Ballard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 21122 William Ballard / Son 8256 Fenton Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2005 | Union, West Virginia Greenhill Cemetery * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee aculer 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACRANIAI HEMORRHAGE Priysician THIRTEEN HOURS /Medical Due to (or as a consequence of): TEN Examiner HYPERTENSION YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Directo (or as a nonsequence of) Examiner and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Onknown CHRONIC ATRIAL FIBRILLATION Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes 2 🗷 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannef of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide l 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Fmodom. SEPTEMBER 7, 2005 RES 000 RESIDENT MEDICAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL BELINDA LU. MD S. HANOVER ST, BALTIMORE 21225 MP 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Certificate of Death Reg. No. 2005 29250								
			Decedent's Name (First, Middle, Last)	·			2. Date of Death		3. Time of Death
	Physicia		Annie W. Barnes				August	29,2005	8:05 A M
	/Medic Examin		4a. Facility Name (If not institution, give stree	at and number)	4b. City, Town,	or Location of Death		4c. County of Dea	
	-Admin	•	Blakehurst Assisted	Living Facilit	y Towson			Baltimon	re e
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y May 7, 19	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		214-38-2872 ^{1□ M}	^{2LXF} 90	rrs. Moriars Days	Trodis IVIIII.	May 7, 19	915 Wes	št Virginia
	Du N		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	be filed within 72 hours efter death with the Maryland ital Hygiene. d other than "natural", or iteme 23e or 28e-f show event, it a Madical Examinator mat be notilized at	٦							1 ☐ Yes 2 🛣 No
		ect	Maryland Baltimore 10e. Street and Number	10w	SON 10f. Zip Code		100	. Citizen of What C	ountry?
		급	1055 W. Joppa Road		2120	14		United St	•
	heath me 23	era	11 Marital Status 12.	Was Decedent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	
S	or Iter	Funeral Director	1 Never Married 2 Married	Armed Forces? I ☐ Yes 2 ☑ No	If Yes, specify Cut	oan, Mexican, Puert	o Rican, etc.)	Black, Whi	
03	rali, o	l by	3	f Yes, Give 2x Year or Dates:	1 ☐ Yes 21 No	Specify:		Specify: W	nite
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade co	on 16a.	Decedent's Usual Occu (Give kind of work done	during most of wor	king 16	b. Kind of Business	/Industry
12	vithin ne. hen	ldm		College (1-4or 5+)	life. DO NOT use retire	ed)			
	iled v Hygie ther t	To Be Cor	12 4 17. Father's Name (First, Middle, Last)	<u> </u>	Teacher	18 Mother's Nan	ne (First, Middle, Ma	ducation	
Maryland	od of		Wyatt W. Wood				. Philpot	den damame,	
2	permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ir.a. M. 9Rce.		19a. Informant's Name/Relationship (Type,	Print) 19b.	Mailing Address (Stree			City or Town, State.	Zip Code)
Ma			Rebecca B. Robey - d		Hillside A			-	
re,			20a. Method of Disposition	20b. Place of	Disposition (Name of	acel	Date 20	c. Location · City or	Town, State
Ë	Page nent o nt: If ry or		1 ☐ Burial 2 反 Cremation 3 ☐ Remo 1 ☐ Donation 5 ☐ Other (Specify)	aval from State	w Crematory	, The 8/	/31/05 Ba	ltimore,	Maryland
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licenses	A.	22. Name and Addr	ess of Facility Huk	bard Fune	ral Home,	Inc.
8	89 1 2 8		Juny y. X	nh	4107 Wilke	ens Avenue	e, Baltimo	re, Maryl	and 21229
П			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complete shock of the complete	ons that caused the death. Do rause on each line.	-			t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	116	heimer's	, di	12118		Onset and Death
	Medical Examiner bulksicien and bulksicien and burial-transit sthe burial-transit		resulting in death)	Due to (or as a consequence	of):				
		_	Sequentially list conditions, b. —	Due to (or as a consequence of	of).				
_		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence (,,,,				
		xar	that initiated events c						
8760,	siciel s buri	dical							
9	ifficat g phy as th	edic	1,700						
Вох	h cert endin use	an/M	230. Was decedent pregnant	f yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 □Ectopic pregnanc	*V		23d. Date of de	
	The law requires that the death certifi tie has been signed by the attending r age 2 should be detached for use as	Physician/Me	1 Yes 2 No	4☐Pregnant at time of death	5 Other (specify)	· · · · · · · · · · · · · · · · · · ·		Month	Day Year
P.0	at the 1 by th etach	Phy	9 Unknown				an Pili	1	
	res tha igned I be det	by	Part II. Other significant conditions contrib	uting to death but not resulting in	eath but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause o	
oro	w require been si should l	ted					10 103	2010 301	ODADLY 4 GORRIOWII
Records,	sicien: The law certificate has b irector, page 2 s	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
al F							1 Yes 2	1 Yes	2 □No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ital:	0:	hor	th (Check only one)		
of	Phy rald	1: To	TIL THS ZIVINO	1 Inpatient 2 ENOU	ime of 28c, Inju	4 ⊡ Nursing ⊓	ome 5 Residence 28d. Describe how		cify)
lon	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	njury Wo	ork?]Yes 2∐No			
Division		ifice	a Devision 6 D Could not be	8e. Place of Injury - At home, fa	rm, street, factory, office		28f. Location (Stree City or Town, S	et and Number or R	ural Route Number,
ā		cal Certification:	4 Tromeide	building, etc. (Specify)			City of Town,	Diale/	
			29a. Certifier 1 Certifying Physicial (Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and	, death occurred at the t	ime, date and place	, and due to the caus	se(s) and manner a	s stated.
	the hin 2, the fundamental the	Medical	one) 29b. Signature and title of certifier	and manner stated.		se number		. Date signed (Mon	
	T will	-	200. Signaturand title of certifier	14100	7 2	1212	250	P/301.	
	5		30. Name and address of person who compl	eted cause of death (Itom 22a) /	Type Print)	~ / 0)		130/00	1 -
	10		John Toron	Domi N	m 6701	N. Ch	arles ST	Tours	- morray
State Registrar SEP 0 8 2005 32 Registrar's Signature									
	Registr	ar	SEP 0 8 2005	Masses St. 1					

State of Maryland / Department of Health and Mental Hygiene 2005 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 2, **Physician** Catherine Callahan R. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare-Perring Parkway Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State County) 0ct. 28, 1910 Mary Land 5. Social Security Number 6. Sex Funeral Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🖫 F 214-14-2168 94 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23e or 28e-f show other treumstic event, the Mcdical Examinat must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7914 Beverly Avenue 21234 U.S.A. death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If Item 27 is marked other then "naturel", or Item 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th Grade Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martin Callahan Mary Jane Pettu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Callahan (nephew) 7914 Beverly Avenue, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. '4 □Donation 5 □ Other (Specify) Parkwood Cemetery 9/6/2005 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Due to (or as a consequent of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 Tes To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) DO-059423 Ndidi Feinberg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Professionature 560 Loch Roven Blud 15te, 303 31. Date filed (Month, Day, State THE WES Registrar

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nit. P nit. P artme ortan injur.		21. Signature of Funeral Service Combee	2. Name and Address of Facility		
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10		30. Name and address of person who completed cause of death (Item 23a) (Type	220 f EAST JOPPA RO	SIET	230 TUNSON 21286
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1.6	non !		30. Name and address of person who	completed cause of de	ath (Item	23a) (Tyne F		.C.M.	i.	A	ugust	30, 2	005	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9-03-2005 Betty Lou Chalk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 340 Schulamar Road Linthicum Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💆 F Director 220-32-3496 69 11-18-1935 MD Usual Residence of Decedent r 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD Anne Arundel Linthicum 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or than "naturel", or Itams 23s or the Medical Examiner Just be c 340 Schulamar Road 21090 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White \$ 3 ☐ Widowed 4 ZDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-Employed Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ... Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked oth jury or other treumatic even Thomas Pumphrey Shipley Claire Chaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bryan C. Chalk / Grandson 6221 Winsted Court; Glen Allen, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9-07-2005 Glen Burnie, MD Glen Haven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home P.A. Mo/357 1 Second Ave SW; Glen Burnie, MD aneure 23a. Part1. Boter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIL **Physician** CARDIOMYS PATIFY /Medical Due to (or as a consequence of): Examiner &THEROSCIELOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine PERCHOLÈSIE RILEMIA attending physicien and for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter a detached for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DUCKWAARY DUCHSE OBSTRUCTIVE CHRONIC 1 Yes 2 No 3 Probably 4 Unknown OLON 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 20 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Naturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9-6-05 send 1100 $\subset \alpha$ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHARM AZENA, MID CHURCH ST. BAUTIMORE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

0.8 2005

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. / Department of Health and Mental Hygiene 005 Amend Item 26 per Verb., G84 29255 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** September Day Year ′3 **,**_ David Carson James 2005 8:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Highland 7150 Brooks Road Howard If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Apr. 10, 1953 Birthplace (State or Foreign Counts) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 52Yrs. Director 215-48-6776 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Howard Highland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7150 Brooks Road 20777 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xlo Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Remodeling 18. Mother's Name Fire Middle Wille Furnitre tcher Be (17. Father's Name (First, Middle, Last) George Carson Fletcher Elizabeth George Carson ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Elizabeth Carson (Mother) | 7150 Brooks Road Highland, MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 9/8/05 Marriottsville, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility</sup> Home & Chapel (Box 195) Haight Funeral Home & Chapel (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCLAR DISEBSE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DISEASE FME 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy rmed? 2 ☑ No 1 Yes 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

Physician /Medical **Examiner** Hospital or Attanding Physician: The law requires that the death certificate be executed the burial-transit physician and Box 68760. signed by Division of Vital Records, tuneral director, page 2 should this Atter after death þ within 24 hours a To the Funeral C

or Itams 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours atter death with the Maryla ment of Heath and Mental Hygiene.
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injury or permit. Page Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier to Mazton MD 29c. License number

29d. Date signed (Month, Day, Year)

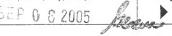
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERT F. MOLTON, M.D. 2802 MONTCLAIR DRUE ELLICETT CTY MD 21643

31. Date filed (Month, Day, Year) State Registrar

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32. Registrar's Signature



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	/Medic Examin		4a. Facility Name (If not institution, given Heritage Nursing		er)		4b. City, Town, o				4c. County		
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1	2/2		30. Name and address of person w	no completed caus	e of death (Item	23a) (Type. I	Print)	*	0 /	/ "	7	11em		', - '
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State of Maryland / Department of Health and Mental Hygiene 29258 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month MARION EPTEMBER-/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner TOHNS HOPKINS HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/04/1944 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral Days Hours 1 ☐ M 2 💢 F 109-34-5752 Director 61 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itams 23a 21208 U.S.A. 3 GREENLEA DRIVE Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White etc. WHITE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 Is merked other the any injury or other treaumatic event, Item once. NURSING EDUCATOR NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ISAACS** ZEPNICK SYLVIA IRVING ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 GREENLEA DRIVE - BALTIMORE, MD 21208 BURTON D'LUGOFF / HUSBAND 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ARLINGTON - CHIZUK AMUNO CONG. 1 Denation 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 09/07/2005 BALTIMORE, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enfer the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease o condition 112ATURL Physician week resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit LAR USE Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Month Year Day 5 Other (specify) 4☐ Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? certificate 20 No 1 Yes 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Vatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To tha Funaral Dire 4 Homicide o the Hospitat 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) 10 SHURKINS HOSPI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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altimore	Page nent o ant: If ury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens	Removal from State 494	HO Easteren Aver 22. Name and Addr	uc 129	2005 Bal	timore	
Ba	permit. Departr Import any inj			Wade Director	State Anat	tomy Board	655 W. Bal	timore	Street
	Physician /Medical		23a. Part . Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of the death one cause on each line.	e premi	Junty	^		Approximate Interval Between Onset and Death
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68760,	icate be executed physician and s the burial-transit	icai Examin	that intitated events resulting in death) Last	c. Due to (or as a consequence d.	uence of):				
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۵.	law requires that the d as been signed by the 2 should be detached	by	Part II. Other significant conditions co	intributing to death but not resi	ulting in the underlying cause g	iven in Part I.	23e. Did tobacco u	se contribute to	the cause of death?
al Records,	The ate h page	Completed					24a. Was an autopsy performed? 1 Yes 2 No	24b. Were aur prior to death? 1 \(\sum \text{Yes}\)	topsy findings available ompletion of cause of No
f Vital	S D	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 🗆	ER/Outpatient 3 DOA	26. Place of Death (ther: 4 Nursing Home	Check only one) B 5 ☐ Residence	3 □Other (Spec	ify)
Division of	ding h. After fune	Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Yes 2 No	d. Describe how injur		
Divi	i i i i		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, office y)	28	If. Location (Street and City or Town, State)		ral Route Number,
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1	To th within To th comp	Me	29b. Signature and title of certifier	12 02		nse number	}	e signed (Month	
,			30. Name and address of person who d	um range completed cause of death (Item	7	3650		7/29/20	785
			Mary Ellen Payone			ern Ave Ba	ltimore, M	d	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) SFP 0 8 20	32. Registrar's Signa	ew 4940 Easte		,		

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			State of Maryland / Department of Health and Me	ental Hygier	1 0 2005 20	200
			Registrar AMEND FIEM #10f&19b PER fh g847/16968/6599Ath	Reg. I		260
	Physici	an	1. Decedent's Name (First, Middle, Last)	Commence of	Day Year	e of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	SEPT. O	4c. County of Death	:65AM
	ZX	Ĭ	SOUTHERN MD. HOSPITAL CENTER CLINTON	1	PRINCE GEORGES	s Co.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (Sta	te or Foreign
	Director		Usual Residence of Decedent	NOV. 25,1	1922 MARY	AND
	yland		10a. State 10b. County 10c. City, Town or Location			e City Limits
	Ba-fs	ctor	MARYLAND A. A. COUNTY GLEN BURN.	1E	1 🗆 \	es 2 No
	with th	Dire	10e. Street and Number 21060	10g.	Citizen of What Country?	
	ns 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - American Indian	1,
ဖွ	after o	Fun	Armed Forces? I Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto R I Married If Yes, Specify: I Yes 2 Mo I	lican, etc.)	Black, White, etc.	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23e or 28e-f show that the Medical Evanicar must be routhed at	d by	3 □ Widowed 4 □ Divorced Year or Dates:		Specify: BLA(K
15-	in 72 t	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	g 16b.	Kind of Business/Industry	
212	d with giene.	шо	Elementary/Secondary (0-12) 12 THGRADE College (1-4or 5+) RIGGER		OAST GUA	RD
	be file tal Hy d othe	Bec	17. Father's Name (First, Middle, Last) 18. Mother's Name (en Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, the Me	ဥ	HOWARD O. FLETCHER ELSIE	= /	4CDONAL	D
Ma	id 2 st th and th s n treun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural VIOLA M. FLETCHER (WIFE) 6500 Home WATER	Houte Number, Cit	- 1 P	21060
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other than "naturat", or Items 23e or 28a-f show or other treumatic event, Ite Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Disposition (Name of Dameters, cramators or other place)	ate / 20c.	Location - City or Town, State	1260
imo	Pages nent of t ant: If Ite ary or of		18 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) LOUDON PARK CEME 09-10	7-05B	ALTIMORE HA	RIKAKS
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	ROUNJ	R. FUNERAL	HOME
	70 F 8 0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		ALTO, MD. 21 Approxim	2/7
	DI		shock, or heart failure. List only one cause on each line.	respiratory agrest,	Interval Onset a	Between Death
,	Physician /Medical		disease or condition resulting in death) Due to (or/as a consequence of):		90	ays
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	be is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mitated events c.		4	92
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8760,	cate be executed physician and the burial-transit	dicai	d			
9	artifica ing ph a as th	Medi	IF FEMALE:			
Вох	ath ce attendi for use	lan/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery Month Day	Year
o.	the de y the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
٥	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Pr	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause	of death?
ords	w require been sig should b	ted t		1 🗌 Yes	2 No 3 Probably 4	□U⊓known
Records,	alaw r nas be e 2 sh	Completed		24a. Was an autopsy	24b. Were autopsy findin prior to completion	
al F	ician: The lav certificate has ector, page 2 :			pertormed 1 Yes 221		<u></u>
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Hom.		6 ☐Other (Specify)	
ιof	ding Phy h. After this funeral o			Bd. Describe how in		
Sion	tendir eath. tor: Af the fur	catic	2 Accident investigation M 1 Yes 2 No			
Division	or Att	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, Sta	and Number or Rural Route N ate)	lumber,
	spitel	al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause	(s) and manner as stated.	
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date a	ind place, and due to the caus	e(s)
	To t To t	2	29b. Signature and tiple of certifier 29c. License number		Date signed (Month, Day, Year	r)
	140		10/m/2MD D-24535		9,03,05	
	271		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	TOU MA	20235	
	Sta	te	DR. LAXMI BERWA, 7503 SURRATTS RD. CLINT 31. Date filed (Mogth, Day Year) 32. Registrar's Signature	-N 17L	1.4010	
E	Registr	ar	The state of the s			

	•	■ State	State of Maryland	I / Depa	rtment of H	lealth and M		ene 200	5 29261
Physici	an	Registrar Decedent's Name (First, Middle, Last) Patrick Leo Fagan			inouto or i	Joann	2. Date of Death Month	. 110.	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution, give str				r Location of Death	epi eme	4c. County of Dea	ith
Funeral Director		244-36-0175	Medical Cente 7. Age (In yrs. la		Bel Ai If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, You Jan. 4,	ear) C	d thplace (State or Foreign ountry) th Carolina
faryland show	Jo.	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc		• 7 7			10d. Inside City Limits 1 ☐ Yes 2 ☐ No X
or 28e-1	Funeral Director	Md. Harford 10e. Street and Number			Forest H		10g	. Citizen of What C	
death w	neral	311 Willrich Circ	ie, Unit F 2. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Vas Decedent of H	50 ispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	U.S.A.	
ours after ral', or Ite	þ	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 XNo If Yes, Give Year or Dates:		Yes 2 No	Specify:	rican, etc.)	Specify: W	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hydiene. And Hydiene dether than "natural; or Items 23a or 28e-f show event, tra Medical Evaning must be ricitlised.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give life. E	OO NOT use retired	during most of working)g	b. Kind of Business	/Industry
if yearto C. I.C. should be filed within to Mental Hygiene. marked other than matic event, the M	a	12 years 17. Father's Name (First, Middle, Last)		millw	right	18. Mother's Name		Repair & l iden Sumame)	Machinery
should be ind Mental in marked umatic ev	ToB	Henry Fagan				Gertrude			7.0
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is market any injury or other treumatic once.		19a. Informant's Name/Relationship (Type Helen Fagan/wife 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Re	20b. Pla moval from State	311 W ace of Dispos metery, crem	illrich sition (Name of natory or other place	D D	ait F. Fo	c. Location - City or	1. Md. 21050 Town, State
permit. Pa Departmen Important: any injury once.		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses			em. Gdns	• 9/9/2 ss of Eacility k Funeral	_	el Air, Mo	
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Fnysician	0 1	shock, or heart failure. List only-one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	10N	0	J MO N I		,	Interval Between Onset and Death
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OI VITAL Physicien: - this certifica ral director, p	o Be (25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 E	R/Outpatien	t 3□ DOA Oth	26. Place of Death er: 4 ☐ Nursing Hon		on 6 DOther (See	20/64)
ding Phy	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injun Worl	yat 2 k? Yes 2 □ No	8d. Describe how		eny)
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To t To t	M	29b. Signature and title of certifier	e gury	, md	29c. Licens	e number 344		Date signed (Mon PTEMBE	th, Day, Year) R 5, 2005
20		30. Name and address of person who com	npleted datuse of death (Kelm UPPER CIT	23a) (Type, 1	Print) EAKE M	LEDICAL	CENER	BELAI	R,MD
Sta Registi		31. Date filed (Month, Day, Year) SEP 0 8 2	2005 32. Registrar's Signatu	ure 2	(mu)				

		1 - For State Registrar	State of Maryl			nt of Health te of Deat			giene	/11/15	29	262
Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last Donald 4a. Facility Name (If not institution, give The Jhns Hopk	Pa e street and number) INS HOSPITO	al	4b. City Bal-	Town, or Location	Jr.	2. Date of Dea Month	Day 4c.	County of Deat	5 6: 1	of Death 48 PM
Funeral Director		Usual Residence of Decedent	⊠ M 2□F 2	yrs. last birth 47 Yr	Months			8. Date of Birt (Month, Da)	y, Year)	Co	hplace (State untry) MD	or Foreign
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ath with th		401 E. 25th St			10f. Z	21218				zen of What Co USA	146	
or the	d by Funeral	11. Marital Status Narried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S.	13. Was Deci If Yes, sp 1 \(\sum Yes\)	edent of Hispanic (ecify Cuban, Mexic 2 No Speci	can, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: B		
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E de la Be	To Be (17. Father's Name (First, Middle, Last) Donald		Sr.		18. Mo	ther's Name Susi	(First, Middle, ie	Maiden	,	kins	
os 1 an of Heal item 2		19a. Informant's Name/Relationship (Joseph Bishop-br 20a. Method of Disposition 1 TBurial 2416 remation 3	cother 20	b. Place of D	L226 N Disposition (Na crematory or	s (Street and Num Curley ame of other place) Cremator	St.	Baltimo ate	re,		21213 Town, State	MD
Baltimore, permit. Pages 1 a Department of Heis Importent: If item any injury or othe once.		*4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			22. Name a	ind Address of Fac	cility M	ARCH E	UNE	ERAL H		AST
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is Digital	edical Cert	29a. Certifier 1 Certifying Pt	building, etc. (Sp nysician: To the best of my miner: On the basis of exan	knowledge,	death occurre	d at the time, date	and place, a	nd due to the	cause(s)	and manner as	stated.	(s)
To the Hospitel within 24 hours a To the Funerell completely filled	Medi	29b. Signature and title of certifier	and manner stated. - M_ Vec	- M.	· 29	265 -00	ar DO		29d. Dat	e signed (Month	n, Day, Year)	-
Sta Regist	ate rar	30. Name and address of person who Jeffrey Venstrom, M. 31. Date filed (Month, Day, Year) SEP 0	completed cause of death (D. Towerle, D.C.) 32. Registrar's S 8 2005	(Item 23a) (T	ype, Print)	600 Morth	h Work	street	Balt	timae, n	naryla	m 21287

	70ga - 161		1 - For State Registrar 1. Decedent's Name (First, Middle, Li			rtificate of	f Death	Reg	ene 200	
	Physici /Medic	cal	Julian Ignatius I 4a. Facility Name (If not institution, gi	Forrest, Jr.		4h City Tourn	or Location of Death	2. Date of Death Month Sept. 5	2005	ar 3:30 A M
- 16	Examir	ner	Gilchrist	ve street and number)		Towso			4c. County of Baltin	
6	Funeral Director		5. Social Security Number 6. 213-30-2877 Usual Residence of Decedent	1□M 2□F	(In yrs. last birthday, Yrs.		r If Under 24 Hrs.	8. Date of Birth (Month, Day, Y Feb. 24	'ear) 9	Birthplace (State or Foreign
5,200	th with the Maryland 23a or 28a-f show	Director	10a. State 10b. County MD Baltime 10e. Street and Number	ore	10c. City, Town or L			10g	j. Cîtizen of Wha	10d. Inside City Limits 1 ☐ Yes 2X No at Country?
inbe	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Important: It item 23a or 28e-f show Important: It item 27 is marked other than "natural" or items 23a or 28e-f show sny injury or other traumatic event, If a Mudical Examinar must be notified at once.	ed by Funeral Director	8 Stepleton Ct. 11. Marital Status 1 Never Married 20 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 DYes 2 No If Yes, Give Year or Dates:	'55-'63	1 □ Yes 2 □ X No	Hispanic Origin? (Spe ban, Mexican, Puerto I o Specify:		Specify:	American Indian, White, etc. White
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	i o the hospitet or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to		4 Homicide determined	building, etc. (9	City or Town, S	itate)	r Aural Route Number,
I	ne Hos n 24 hc he Fun pletely	edical	(Check only 2 Medical Examone)	nysician: To the best of r niner: On the basis of ex and manner stated	camination and/or in	occurred at the trestigation, in my	ime, date and place, ai opinion, death occurre	nd due to the caus d at the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
	within 2 To the comple	Σ	29b. Signature and title of certifier	lun			se number		Date signed (M PtcmLt	
	14	10	30. Name and address of person who Chente 31. Date filed (Month, Day, Year)	completed cause of deat COMPONIE 32. Registrar's	301 N-1	Ma de	u (t to	wien -	no 2	1204
	Sta Registr	-	SEP 0 8		M. M.	End.				
DHM	H 17 Rev 1/20	001		1-00	ORIGIN	AL				

State of Maryland / Department of Health and Mental Hygien 2005 29264 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** SEPT. 2005 Year SAMUEL FISHBEIN 3:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3501 CLARKS LANE APT. 2-B BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 05/23/1917 9. Birthplace (State or Foreign Country) RUSSIA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F 88 215-32-3881 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Example registed at BALTIMORE MD N/A 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 CLARKS LANE APT. 2-B 21215 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. WHITE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Saltimore, Maryland 21215-0036 Specify Specify ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ RABBI RELIGION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FISHBEIN YAAKOV BURAK FEIGA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8484 16th STREET - SILVER SPRING, MD 20910 APT. 104 JOSEPH LEVIN / COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any Injury or once. HAR HZEISIM 09/08/2005 JERUSALEM, ISRAEL 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. REISTERSTOWN ROAD -Interval Between Onset and Death Immediate Cause (Final Enysician 1ETASTATIC Moren45 disease or condition resulting in death) /Medical Examiner TASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HRANIT The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Dav Month signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AR TER 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 24 hours after death. e Funeral Director: A М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2001 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per BORIS 1 REF G-REFINE 31. Date filed (North, Day (Year) 2005 Registrar's Signature State Registrar

			1 - State of N	laryland / Dep <i>Ce</i>	artment of Health a ertificate of Death		gien 2005 29265 leg. No.
	Physici /Medic		Decedent's Name (First, Middle, Last) JACK LAMAR GREEN			2. Date of Dear Monthy	Day / Year - 2/0
	Examir		4a. Facility Name (If not institution, give street and number Second French Land Community Number 6. Sex 7. 7.	spital	4b. City, Town, or Location of Bull-moke (Death 1	4c. County of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 7. A 2 F 7. A 2	82 Yrs.	Months Days Hours	Min. 8. Date of Birth (Month Day)	9. Birthplace (State or Foreign County) GEORGIA
	faryland show	o.	10a. State 10b. County MD N/A	10c. City, Town or L	ocation IMORE CITY		10d. Inside City Limits XXYes 2 □ No
	th the Nor 28a-	Director	10e. Street and Number	DALI	10f. Zip Code	1	Og. Citizen of What Country?
	ath wi	raiD	3707 GWYNN OAK AVEN		21207		USA
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other than "natural", or Itams 23a or 28a-f show or other treumatic event, the Medical Examinar must be positive at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give	i? No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
Maryland 21215-0036	n 72 ho "natur edicel	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occupation a kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/Industry
212	filed withi Hygiene. vther than snt, the M	Somp	Elementary/Secondary (0-12) College (1-4o	75+)	CK DRIVER		TRANSPORTATION
and	2 should be filed and Mental Hygi Is marked other eumatic event,	Be	17. Father's Name (First, Middle, Last)			's Name (First, Middle, M	Maiden Sumame)
ary	should ind Men s marke umatic	Ţ	UNKNOWN 19a. Informant's Name/Relationship (Type, Print)	19b. Maili		NOWN or Rural Route Number	, City or Town, State, Zip Code)
	1 and 2 Health a lem 27 le		GLORD MCGUIRE / CARE PROVID	ER 370	7 GWYNN OAK	AVE., BAL	FIMORE, MD 21207
altimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	B	matory or other place)		20c. Location - City or Town, State CATONSVILLE, MD
Baltir	permit. F Departme Importer eny injur		21. Signatur Johneral Service Licensee		2. Name and Address of Facility		UNERAL HOME 21207
68760,	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate and and age 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, nary, bearing to manufacture ause. Enter Underlying Cause (Disease or injury that initiated avents	ed the death. Do not en	ter the mode of dying, such as c	ardiac or respiratory arre	VE., BALTTMORE, MD Approximate Interval Between Onset and Death
O. Box	the death certific by the attending p ached for use as	Physician/Med		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
S, D	res that the de signed by the a be detached f	by PI	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given in Part I.	Lin	pacco use contribute to the cause of death?
Records,	w requir been si should	ieted	Cacemona of M	2 1005/00	The services		s 2 No 3 Probably 4 Munknown
_		e Completed by	25. Was case referred to medical		26 Place o	24a. Was ar autops, perform 1 Yes 2 of Death Check onlone	prior to completion of cause of death? No 1 Yes 2 No
on of V	To the Hospitel or Attending Physicien: whim 24 hours after deals. To the Funerel Director: After this certifical completely filled in by the funeral director.	tion: To B	examiner? 1	ury 28b. Time o	nt 3□ DOA Other: 4□ Nurs	sing Home 5 Resider	nce 6 Other (Specify)
Division	tel or Atter	Certification:	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farm, str tc. (Specify)	reet, factory, office	28f. Location (Str City or Town,	reet and Number or Rural Route Number, , State)
	Hospi 24 hou Funer stely fill	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the bes 2 Medical Examiner: On the basis and manners	of examination and/or in	h occurred at the time, date and vestigation, in my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manner as stated. Ite and place, and due to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, Day, Year)
			Amaton M Nat		D 155	503 5	eptember 6 2005
	8		30. Name and address of person who completed cause of PMATU U NAE	death (Item 23a) (Type,	1 Delphin	ST Ral	himore, MD 21217
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	w	,	

Jack GREEN

State of Maryland / Department of Health and Mental Hygienes 29266 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18:12 M 05 2005 MATTHEW R. GREGORY /Medical 4a. Facility Name (If not institution, give street and number)
St. Agnes Hospita 4c. County of Death Examiner Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Securit Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F Yrs. 219-40-2888 Director MD 11-18-1943 61 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Director BALTIMORE 1X Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 USA 205 BEACHFIELD **AVENUE** Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN RETAIL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any njury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BLANCHE CARTER GEORGE A. GREGORY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 CENTER ST., BALTO., MD 21222 KENNETH GREGORY/BROTHER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balton 4 □ Donation 5 □ Other (Specify) 09/12/05 Arbutus 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701 LAURENS STREET, BALTO., MD 21217 Rant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiores piratory failure due to **Physician** Days /Medical Examiner Rhabdomyolysis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner physician and the burial-transit Atrial Fibrillation with Rapid Ventrieular Response that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai use as t the attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? for Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No page 2 should Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death / Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A
completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitei Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P06062 726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Champa Abeysinghe St. agnes Hospital, 900 Caton Avenue, Baltimore MD 21229 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 8 2005 0 Registrar

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State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Year **Physician** 2:14 A.M 04 2005 GRIFFIN HERBERT D. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, 12-23-Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD Months Days Hours 1XM 2□ F MD Vrs Director 65 216-34-6812 Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10b County 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director TURNER STATION MD BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò USA 238 105 CALVIN HILL COURT 21222 or Itame 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Marned Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) FIRESTONE TIRES 12 TIRE SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IRENE MASON WILFORD GRIFFIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
105 CALVIN HILL CT., TURNER STATION, MD 21222 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Depurtment of Health a Important: If itam 27 ts any njury or other tra 2005. FRANCES GRIFFIN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEM 09/08/2005 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service License JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nenatocellular Carcinoma disease or condition resulting in death) months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 4curs Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Division of this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 1X Natural 5 Pending within 24 hours after death. To the Funaral Director: A 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint) 10 CHMIRS 6601 N Charles St TOWSON MO 21204 32 Registrar's Signature State

Registrar

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		1 - For State Registrar	State of Mar		artment of I rtificate of			giene 2005	29268
_	sician ledical		Howell				2. Date of Dea Month	Day Year	3. Time of Death
Fune Direct		5. Social Security Number 234-26-4746	ARE HOS	n yrs. last birthday) 81 Yrs.	4b. City, Town, of 12 OS of 15 Under 1 Year Months Days			4c. County of Deal BA / Ti A Parl Co. 1923 Wes.	
he Maryland 8a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Balti		Oc. City, Town or Lo	White Ma	rsh			10d. Inside City Limits 1 ☐ Yes 2 🕱 No
ath with U	rai Dire	109. Street and Number 10935 Philadel	phia Road		10f. Zip Code	21162		10g. Citizen of What Co	untry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f ehow with intermed to the contraction of the co	d by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No		pecify Yes or No- o Rican, etc.)		
21215- d within 72 giene. or then "net	Completed	15. Decedent's E (Specify only highest grant property) Elementary/Secondary (0·12) 12th Grade		(Give	dent's Usual Occup kind of work done DO NOT use retire NEMAREL	oation during most of wor d)	king	Own Home	Industry
Maryland 21215-0036 at 2 should be filed within 72 hours all lith and Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last Irvin Ray Mi	ller			Ida P	earl wi		
and 2 st ealth and m 27 is n		19a. Informant's Name/Relationship ((husband)	1093	5 Philade	elphia Rd	., White	r, City or Town, State, 2 Marsh, MD	
Baltimore, Department of Heat mportment of Heat mportment if Item	5	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	I tottioval ilotti otate	20b. Place of Dispo cemetery, cree Holly Hi			Date / 2005	20c. Location - City or Baltimore	
Baltim permit. Pag Department Important:	- 500G	21. Signature of Funeral Service Licer	Rina	Re 1 2	2. Name and Addre	ir Rd., 1	himunek Baltimor	Funeral Hom e, MD 21236	10 A
Physici /Medic Examir	cal	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a. A c u Te	MI	er the mode of dyn	ng, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
8760, sate be executed by sician and the hurial transit transit and the hurial transit a	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c						
Box 6 ath certific	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of particle birth 2 [4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of deli Month	very Day Year
cords, P.O. I w requires that the de been signed by the a	র হি	Part II. Other significant conditions of	ontributing to death but r	ot resulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records, to Attending Physician: The law requires tatler death. Director: After this certificate has been signed in by the funeral director, page 2 should be a							24a. Was a autops perfori	by prior to death?	topsy findings available completion of cause of 2 No
on of Vital Reding Physician: The Land. After this certificate ha	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Oth	er	th <i>(Check only</i> on ome 5☐ Reside	ee) ence 6 □Other <i>(Spe</i> d	ufy)
ion conding Path.	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yo	28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe ho	ow injury occurred	
Division of Vital To the Hospital or Attending Physician: Within 24 hours after death, To the Funeral Director. After this certified completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
he Hosp n 24 hou he Funei	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the vithing to the company	×	29b. Signature and title of certified with the way and title of certified the way and the	/hten		29c. Licens			9d. Date signed (Month)	
6		DR. MICHELLE Ho	15TON 900	20 FRAN	Print) Kliv S	QUARE.	DR. BAI	Timore /	ud 21237
22 ST 22 ST	State istrar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	20.	U			

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Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit Box 68760 P.O. the ģ Division of Vital Records,

1 - For State Registrar Certificate of Death 2. Date of Death Decedente Name (First, Middle, Last) Dav Month Year **Physician** 7:00 D. M SEPTEMBER 2,2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Burnie Washington Medical Center Baltimore Glen If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) ce (State or Foreign **Funeral** 1 □ M 2 □ Director 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
• is marked other then "neturel", or Items 23a or 28a-f show 10c. City, Town or Location County ns 23a or 28a-f shor 1 ☐ Yes 2 ☑No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code el and Numbe 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status other treumetic event, the Medical Examiner Black, White, etc. 2 1 1 Never Married 21 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced edent's Usual Occupation e kind of work done during most of working DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Patner's Name #First, Middle, Last Be yvn State Zip Code) Department of Health Importent: If item 27 City or Town, Style 20a. Method of Dispo Mon 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service L any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Lancer Metastatic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 🗌 Yes No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funerel C ↑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO055973 2,2005 September 1cassaL M.D helelu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20904 11500 culherland SILVER EPVING, MB way Desse agistrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 8 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar		artment of Health and rtificate of Death		ene 2005	29270
Physic /Medi		1. Decedent's Name (First, Middle, Last) NBNCY HORE	9<		2. Date of Death Month	Day Year 3 2605	3. Time of Death /:45.4 M
Exami	ner	4a., Facility Name (If not institution, give street and 4214 EVANS CHAP 5. Social Security Number 6. Sex	d number) EL ROAD 7. Age (In yrs. last birthday)	4b. City, Town, or Location of D	IORE	4c. County of Deat	
Funeral Director		213·20·8191 1□ M 202 Usual Residence of Decedent			Hrs. 8. Date of Birth (Month, Day, Y	'ear) Co	hplace (State or Foreign unity) TH CAROLINA
e Marylan 8a-f show Lillied at	Director	10a. State 10b. County	10c. City Town or Lo	ocation MORE			10d. Inside City Limits 1
sath with the s 23a or 2		4216 EVANS CHAR		10f. Zip Code 2/2/1	8	Citizen of What Co	.A.
-0036 hours after death with the Maryland tural; or Items 23a or 28a-f show at Examiner must be notilited at	by Funeral	1 Never Married 2 Married 1 1	es 2 No	Was Decedent of Hispanic Origin? If Yes, specify Cyban, Mexican, Po	/ (Specify Yes of No- uerto Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036 d within 72 hours after death with the Marylan giene. ar than "natural", or liems 23a or 28a-f show ar than "natural" or liems 23a or 28a-f show the Modical Exomitrer must be nutilized at	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle	ted) (Give	dent's Usual Occupation a kind of work done during most of DO NOT use retired)	working 16	6b. Kind of Business/	•
land 21	To Be Co	17. Father's Name (First, Middle, Last) FDNIALT TARENT		18. Mether's	Name (First, Middle, Ma	FOO:	D
ire, Maryland Stand 2 stand 2 should be filed thealth and Mental Hygism 27 is marked other traumatic ayent.	Ī	19a. Informant's Name/Relationship (Type, Print) WESLEY HORDEE (S	19b. Maili 153	ng Address (Street and Number of		/.1	ip Code) 1D 2/2/8
0 0 = 2		20a. Metrod of Disposition 1 Burial 2 Cremation 3 Removal f 4 Donation 5 Other (Specify)	rom State 20b. Place of Dispo cemetery, creating KING M	osition (Name of matory or other place) EMORIAL PARK 2. Name and Address of Facility	Date 20	c. Location - City or	Town, State
Baltim pernit. Pag Deportment Important: any injury o		21. Signature of Funeral Service Licensee	Suit 4	2. Name and Address of Facility 905 York Romu	BANTIMO	REENE FUND RE, MARYLA	ERAL HOME WD 2/2/2
Physician		23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	nat caused the death. Do not entone each line.			ı, ' '	Approximate Interval Between Onset and Death L
/Medical Examiner	<u>.</u>	Sequentially list conditions b. Y	e to (or as a consequence of): One of the consequence of the conseque				Year
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P.O. Box 6876(that the death certificate be ed by the attending physicial detached for use as the bu	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
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of Vital F Physician: Th r this certificate rat director, pag	Be	25. Was case referred to medical examiner? Hospital:	_	Othor	Death (Check only one)		
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To tha Hospital within 24 hours a To the Funaral I completely filled i	edical	29a. Certifier (Check only one) 1. Certifying Physician: To 2 Medical Examiner: On the and it	o the best of my knowledge, death ne basis of examination and/or in nanner stated.	h occurred at the time, date and pla vestigation, in my opinion, death of	ace, and due to the caus ccurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To t with To th	M	29b. Signature and title of certifier	nn e	29c. License number	29d.	SRM 6,	OJ
3		30. Name and address of person who completed	cause of death (Item 23a) (Type, 2/16 May)	Print) loud sie Bol	6, rd 2121	8	
St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 8 2005	2. Registrar's Signature	h occurred at the time, date and playestigation, in my opinion, death of 29c. License number 17 2 2 0 3) Print) Print) Print) Print) Print)			

DHMH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, Month **Physician** 2005 Reginald Holmes August 8:16An /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Harbor Hospital Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 2 M 2 □ F Director 69 212-34-7757 Jun 14, 1936 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 77 is marked other than "naturel", or items 23e or 28e-f show treumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2392 Seamon Avenue 21225 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐(No Specify: Ş Q If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other treametin. Elementary/Secondary (0-12) College (1-4or 5+) Trailways Bus Company Cook 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Holmes Lila F. Hughes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Holmes 2392 Seamon Avenue - Apt T Baltimore, Maryland 21225 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 09/02/05 Catonsville, Maryland Metro Crematory, Inc. Funeral Service Licensee 21. Signatu 22. Name and Address of Facility CV Estep Brothers Funeral Service 1300 Eutaw Place, Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Pulmunary Aspiration Sequentially list conditions, it any scaling to immunity cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consumence of burial-transit GIB Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical Cardiovascullar Disease the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĺ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the detached à signed & Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Hyperlipidemia has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2X No To the Hospitel or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death Check on one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XDOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 1½ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Sign 29d. Date signed (Month, Day, Year) ne and address of person who completed MO 2122 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 0 8 2005 Registrar

CT 05-05993 Harris, L

	an	1. Decedent's Name (First, Middle,	ŕ				2. Date of Do Month	eath Day	Year	3. Time of Death
/Medic	al	LEONARD M. 4a. Facility Name (If not institution, g	HARRIS		4b. City. Town	, or Location of D	Septe		2005	8:36 AM'
⊏xamın	er	Bon Secours Hosp				imore	out.	10. 000.	ny or Doubl	
Funeral Director		218-62-9875	. Sex 1 Am 2 F 7. Age (In ye	rs. last birthday) Yrs.	If Under 1 Yea Months Days		Hrs. 8. Date of Bi (Month, Di 10-5-	rth ay, Year) 1954	9. Birthpta Countr	ce (State or Foreig y) MD
28a-f ehow notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD	10c.	City, Town or Lo Ba	ocation 11timore 1665 AVE	'NU E			100	d. Inside City Limit
be no	Director	10e. Street and Number	TITE .		10f. Zip Code				of What Countr	y?
al', or items 23a or 28a-f ehov Examinar must be nollified at	y Funeral	1611 RIGGS AVE	12. Was Decedent Ever in Armed Forces?	- 1	212 Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🖾 No	Hispanic Origin Iban, Mexican, Pi	(Specify Yes or No Jerto Rican, etc.)	USA 14. Ri Spec	ace - America lack, White, et	c.
onatural, or edical Exam	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest	Year or Dates: Education grade completed)	16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation	working		Business/Indu	
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Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, La LINWOOD J. HARR	•				Name (First, Middle STER BROW		ame)	
Department of Health and Nenial Hygene. Important: If item 27 is marked other than "natur eny injury or other traumatic event, the Madical I once.		19a. Informant's Name/Relationship GAYLE HARRIS / SI 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	STER 20b	1611 D. Place of Dispo cemetery, cren	1 RIGGS	AVENUE	BALTIMOR Date	E, MARY 20c. Location	LAND 2	21217
Departme importen eny injury once.		4 Donation 5 Other (Spe 21. Signature of Funeral Service Lic		22	2. Name and Add	ress of Facility	JAMES A.		& SONS	
D III	cal Examiner	Sequentially list conditions, if my second temperature cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons c. Due to (or as a cons	uence of∤						
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		Decedent's Name (First, Middle, Last)						2. Date of Deatl	h	3. Time of Death
Physicia /Medica		Irvin H. Jett						SEPTEMBI		9:25 A. ^M
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Funeral		VA MARYLAND HEALTH CAF 5. Social Security Number 6. Sex		(In yrs. las	t birthday)	If Under 1 Year	ERRY POII If Under 24 Hrs.			CECIL Birthplace (State or Foreign
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				10d. Inside City Limits
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"natural",		15. Decedent's Education			16a. Deced	ent's Usual Occupa	ation		16b. Kind of Busin	ess/Industry
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2 should be filed within and Mental Hyglene. Is marked other than aumatic event, the M	To Be	Elton Jett					Emma	Lappe		
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and 2 ealth in 27 i			ighte			Deviati				21236
permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trea		20a. Method of Disposition 1 Ø Burial 2 □ Cremation 3 □ Removal	rom State	cerr	netery, crem	sition (Name of natory or other place	θ)		20c. Location - Cit	
artmer ortant: injury	í	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licensee		More		Mem'l Pa Name and Addres				e, Maryland
Page 3		Alexand K	enel	Ron		705 Bela				236
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Physician		Immediate Cause (Final disease or condition resulting in death)	HRONI	C OBS	TRUCT:	VE PULMO	NARY DIS	EASE		Onset and Death UNKNOWN
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The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	an/M	230. Was decedent pregnant	, outcome			Ectopic pregnancy			23d. Date o	
the att	Physician/M	in the past 12 months?	regnant at Inknown			Other (specify)			Month	Day Year
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	edical C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and		examinatio						
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3.11		Jiany		hang.	M.1	() ()	010105812	201 5	SEPTEMBER	3, 2005
6+1		30. Name and address of person who completed JIANYI ZHANG, M.D., N					VSTEM. DI	ERRY POIN	יים. אר פו	902
Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	re		LULLI/ II	TACT LOTI	/ 23	
Registra	ar	SEP 0 8 20	15 A	Carling a	A	Arack 1				

DHMH 17 Rev 1/2001

ADH DAVID ALAN JUNK 05-6037

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 4, 2005 **Physician** 0127 A M David Alan Junk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 850 LEISTER SCHOOL ROAD WESTMINSTER CARROLL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Days Hours 54 Yrs. 219-58-6669 Director Maryland SEP 20, 1950 Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits r than "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 850 Leister School Road 21157 USA filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No tf Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Construction and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Depertment of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event once. Be Ivan DeKalb Junk ၉ Beatrice Ida Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7909 Brookford Circle, Apt. D Pikesville, MD 21208 of Disposition (Name of Date 20c, Location - City or Town, State Maren E. Junk/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/7/05 Baltimore, MD 21. Signature of Funeral Service Ocensee

Edward A Gregorchik 22. Name and Address of Facility
Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GWISHOT would /Medical Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physicien at s the burial-t Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sign, page 2 should b 2) No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1) Yes After this certification 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE ၉ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No SUBJECT SHOT SELF 05 1114 A 2 Accident **Director:** 6 Could not be determined 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 950 Colster X Hill Number, WEXTMINITEN, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by vesidence within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

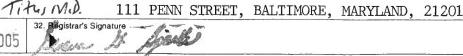
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME SEPTEMBER

State Registrar

31. Date filed (Month, Day, Year) SEP 0 8 2005

JALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



		•	For State Registrer	State of Maryland	/ Depa	rtment of H	Health and <i>Death</i>		giene Reg. No. 20	105	29275
	Physici	_	1. Decedent's Name (First, Middle, Last)	Alban		,	ones	2. Date of De Month Septen	ath Day	Year 2005	3. Time of Death 13:41 PM
	/Medic Examin	-	4a. Facility Name (If not institution, give s The Johns Ho, 5. Social Security Number 6. Ses	okins Hospita		4b. City, Town, of Baltin Mill Under 1 Year Months Days	nove C	ity rs. 8. Date of Bin	4c. County	of Death	ace (State or Foreign
	Director		212-42-9453 Usual Residence of Decedent 10a. State 10b. County	t ^M 2□F 58	Yrs.		Hours M	10 6	1946		MD d. Inside City Limits
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	with	ρ	2128 E. Nort	h Avonue			1010			S A	ıyı
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow or other traumatic event, the Medical Evantrier must be notified at	Completed by Funeral		12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				(Specify Yes or No erto Rican, etc.)		ce - America ck, White, e	
21215-0036	d within 72 h piene. r than "natu ine Medical	ompiete	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th	cation a completed) College (1-4or 5+) N/A	(Give l	ent's Usual Occup kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of B		ustry
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Balti	permit. Pages 1 Department of He Important; if Iten any in ury or oth		21. Signature of Funeral Service License	10 anes		Name and Addre		ARCH FU	JNERAL Baltimo		E-EAST ID 21202
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Box 68760,	ne death certificate be executed the attending physician and hed for use as the burial-transit	Physician/Medicai Examiner	that initiated events resulting in death) Last	Due to (or as a consequent.) 3c. If yes, outcome of pregnant 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	cy leath 3	Ectopic pregnanc Other (specify)	у			te of deliver	y Day Year
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Divis	al or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tov	Street and Numb vn, State)	er or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	on and/or inv	estigation, in my	opinion, death oc	curred at the time,	date and place,	and due to t	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, D	ay, Year)
	0		Jane Sc	hell, Media	cal ooc	to Kes	- 000		Septem	ver 5	, 2005
1	100		Jane Schell	and manner stated. Medical Me	opkin	S Hospi	tal, 600,	North Wolf	e Street,	Balti Maryli	more and 21 287
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	Physicia /Medic		1. Decadent's Name (First, Middle, William Her		er, Sr.						Septemb		:005	5:00 A. M
	Examin		4a. Facility Name (If not institution, § 621 W. 36th Str)		4b. City, 1 Balt		Location o	f Death			y of Death N/A	
	Funeral Director		5. Social Security Number 220–14–0775		ge (In yrs. last b	irthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth Nov • O	h V. Yearh	9. Birthi	place (State or Foreign ntry) Land
	Maryland -f show fied st	tor	Usual Residence of Decedent 10a. State 10b. County N / A	A	10c. City, Too Balti									10d. Inside City Limits
	with the ta or 288	Director	10e. Street and Number 621 W. 36th Str	reet			10f. Zip (Code 1211				10g. Citizen of US		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, If a Medical Enaminal representations once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces	?			ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ack, White,	can Indian, etc. Vhite
Maryland 21215-0036	within 72 hou ane. than "nature ne Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or		(Give lite.	dent's Usual kind of word DO NOT use ICator	k done d e retired)	ition uring most	of worki	ing	16b. Kind of E		City Schools
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Mary	d 2 shouth and Mand Mand Mand Mand Mand Mand Mand	-	19a. Informant's Name/Relationship Helen Knauer	о(Турв, Print) Wife	19		-				Raltim	-		o Code) nd 21211
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Baltimore,	permit. Pa Departmen Important any injury		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice		Park	22	Ceme L Name and Surgee 631 F	Address	s of Facility	v	Funeral			Maryland 21211
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	811		30. Name and address of person w	ho completed cause of	death (Item 23a) (Туре,	Print)	12	U7	40	2016 RUILC	E m	O	21023
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Funer Direct		5. Social Security Num 215-40-72		7. Ag	e (In yrs. last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
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arylan show			0b. County		10c. City, Town	or Location				10d. Inside City Limits
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To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours affer death, within 24 hours affer death, or the Fundard Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as at	edical	29a. Certifier 1[(Check only 2[one)		sician: To the best of er: On the basis of and manner sta	examination and	death occurred at the tir or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date	(s) and manner as and place, and due	stated. to the cause(s)
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F > F 0		D Da	orge C	Wi	le M	MD. D4	1365	Se	ptember	1,2005
n		30 Name and address	s of person who con	mpleted cause of de	eath (Item 23a) [Type, Print)	1365 tal Driv	01	D .	MD 210/1
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			1- State of Maryland / Dep	eartment of Health and Nertificate of Death	lental Hygie	ene 2005	29278
	Diam'r.		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medic		Christy M. Larrimore		Septembe		7:00 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Future Care - Homewood	Baltimore If Under 1 Year If Under 24 Hrs.	10.5	n/a	
	Funeral Director		5. Social Security Number Continue	Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 28,	ear) Cour	place (State or Foreign
			Usual Residence of Decedent		ray 20,	1978 Mary	Land
	nylan how		10a. State 10b. County 10c. City, Town or I	ocation		1	0d. Inside City Limits
	Ba-f s	cto	Maryland n/a Baltimo	ore			1 X Yes 2 No
	vith th	Director	10e. Street and Number	10f. Zip Code	-	. Citizen of What Cour	*
	s 238	era	2700 North Charles Street	21218		nited State	
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 ▼ Never Married 2 Married 1 → Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Americ Black, White,	
93	urs al	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
2-0	be filed within 72 hours after death with the Maryland tal Hygiene. od other then "netural", or flems 23a or 28a-f show event, the Medical Exaft are mest be tradified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	16	b. Kind of Business/In-	dustry
2	within ene.	John	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	e filed within al Hygiene. other then '		10 0 HC	memaker		Home	
anc	od of	Be c		Linda M.	e (First, Middle, Ma Cainey	iden Sumame)	
Maryland 21215-0036	should be nd Mental marked umetic ev	2	Dennis James Larrimore, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Run	_	City or Town State Zin	Code
	d 2 th a 7 is		1 1 2 1	Furrow Street, Bal			,
re,	is 1 an of Heal item 2 other		20a. Method of Disposition 20b. Place of Disposition	osition (Name of Interpretation of Interpretatio	Date 20	c. Location - City or To	wn, State
E	Page nent c int: If		The durial 2 Cremation 3 Hemoval from State	Cemetery 9/9/2	2005 I	Baltimore,	Maryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.			2. Name and Address of Facility Hub 107 Wilkens Avenue			
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		·		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	e Deficiency S	4 refrance		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	9	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
V	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ó	an an	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dlcal	d				
9	artifica ing pl e as t	Med	IF FEMALE:				
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delive Month	ry Day Year
o.	e स् क्	ysic	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			
Д.	res that the igned by be detact	by Physiclan/Me	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
Records,	The law requires that ate has been signed b bage 2 should be deta	q p			1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
00	law requii as been s 2 should	olete			24a. Was an	24b. Were autor	osy findings available
	The lay	Completed			autopsy performed 1 ☐ Yes 2 ∑	d? death?	npletion of cause of 2 No
Vital	ysicien: The is certificate hadirector, page	Bec	25. Was case referred to medical examiner?	26. Place of Death			
of V	Physicien: this certific ral director,	P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 🗌 Residenc	e 6 Other (Specify)
n c	ling F After funera	lon;	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how i	injury occurred	
Division	Attending at death. ector: After by the funer	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	M 1 Yes 2 No	28f Location /Stree	at and Number or Rura	Pouto Number
<u>></u>	after after Dire	Certification;	4 Homicide determined building, etc. (Specify)	rest, factory, office	City or Town, S	State)	noble wallber,
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a livestigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
)	->-0		MO MO	D0059056	0	3/1/2	
	ال		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		11002	
	4		Daljeet S. Salvie MD 6821	Reisterstown R	> B=14	MO 21	215
	Sta		31. Date filed (Month, Day, Year) 82. Registrar's Signature	H. 1	,-		•
	Registr	dľ	SEP 0 8 2005 Reserved to 1	Q.C.			

		For State Registrar	State of N	1 arylan	id / Depa <i>Cei</i>	artme rtifica	nt of H te of L	lealth a	and M	ental Hy	giene2	005	29279
Physic	ian	1. Decedent's Name (First, Middle,	•	10	CVIE	= (1				2. Date of De Month	Day	Year	3. Time of Death
/Medi Exami		ANGELA 4a. Facility Name (If not institution,			CKLE		, Town, or	Location	of Death	09	4c. Cou	7005 unty of Death	01:50 PM
Lxaiiii	ilei	UNIVERSIT	OF MAI	RYLA	WD			TIM					
- Funeral Birector		229-90-3160	. Sex 7. A 1 ☐ M 2 🔏 F	ige (In yrs. 4	last birthday) 9 Yrs.	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 12-03	th Year) 1955	9. Birthpl Coun Virgi	
land bw		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						11	Od. Inside City Limits
Mary a-fsh	tor	MD	NA		I	Baltin	ore						1 X Yes 2 □ No
or 28	Funeral Director	10e. Street and Number				10f. Z	ip Code	01016			10g. Citizen	of What Coun	try?
eath v	erai	1802 N. Dukeland St	12. Was Deceder	t Ever in II	S 13 V	Was Dec	adent of Hi	21216	gin? (Spe	cify Yes or No	. 14 F	USA Race - Americ	an Indian
Defititione, Interpretation Z I Z I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Fun	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	? No			ecify Cuba 2XNo	Specify:	n, Puerto I	cify Yes or No Rican, etc.)		Black, White, e	etc.
72 hou	ted	15. Decedent's (Specify only highest	Education		16a. Deced	dent's Us	ual Occupa	ation during mos	t of workir	ng.	16b. Kind o	of Business/Ind	
vithin 72 ne.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. I	DO NOT	use retired)	(OI MOIKII	<i>'</i> 9	a		
filed v Hygie thert		12 17. Father's Name (First, Middle, La	st)		2	ecret	ary	18. Mothe	er's Name	(First, Middle		te Goveri	nment
id be filk fental Hy ked oth	To Be	Edward C. Lockley	•							Belle Wa		,	
2 shou and N is mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	s (Street a			5.000 CT 110		wn, State, Zip	Code)
and and marking mark		Eric Lockley/ Son		005 5				Road I		ore, MD			
ages 1 nt of H : if ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		, c	Place of Dispo emetery, crem n Hill B	natory or	other place			ate		on - City or To	wn, State
Datumor Permit. Pages Department of Mportant: If it ony injury or o		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lin		210				s of Facilit			Grouces	ster, VA	
Depa Dermi					100				-	638 N.G	ilmor St	t. Balto.	, MD 21217
Physician /Medical Examiner		23a. Part1. Enter the disease, of cashock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	s a conseq	AID,	s the mo	de of dying	g, such as	cardiac o	respiratory a	rest,		Approximate Interval Between Onset and Death
ate be executed hysicien and the burial-transit	i Examiner	if any, leading to immediate cause. Enay Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a										
physical phy	dicai		d									- 17	
The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	I death 3]Ectopic] Other (s	oregnancy pecify)					Date of deliver Month	ry Day Year
r requires that requires signed to should be dete	by P	Part II. Other significant condition	contributing to death	but not res	ulting in the ur	nderlying	cause give	en in Part I	·	1	obacco use c ⁄es 2□No		e cause of death?
The law requirate has been sipage 2 should	completed									24a. Was autor perfo 1 Yes	rmed?	b. Were autop prior to con death? 1 \(\sum \text{Yes} \)	esy findings available apletion of cause of
Physicien: This certificater, predictor, pre	Be C	25. Was case referred to medical examiner?		10 000	- 20					Check only o	пе)		
Physi this o	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpa		ER/Outpatien 28b. Time of		OA Cthe 28c. Injury					Other (Specify)
SICIE tending leath. tor: After the funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of In (Month, D	ay Year)	Injury	м	Work	(? Yes 2 □		8d. Describe I	iow injury occ	curred	
ol or Attensis after deal	Certification;	3 Suicide 6 Could no determin	be 28e. Place of I	njury - At ho etc. (Specif	ome, farm, stre					8f. Location (S City or Tox		imber or Rural	Route Number,
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	edicai C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the bes aminer: On the basis and manner	of examina	wledge, death tion and/or inv	occurred estigation	d at the tim	e, date an pinion, dea	d place, a th occurre	nd due to the d at the time,	cause(s) and date and plac	manner as sta	ated. the cause(s)
To ti To ti comp	W	29b. Signature and title of certifier	14 4 4				c. License				29d. Date sig	ned (Month, E	Pay, Year)
		· Mr	MI)				072				01 2	-
3		30. Name and address of per EVD N NL IV	ntam la	22	Sout	th	Gr	ren	St	- Bal	Amore	MD	2120
St: Regist	ate rar	31. Date filed (Month, Day, Year)	005 Zamegis	uars Signa	Rure	3 300							

DHMH 17 Rev 1/2001

			For State Registrar		of Marylai		artment of He tificate of D		F	Reg. No.	05	292	80
	Physici	an	Decedent's Name (First, Midd		N				2. Date of Dea Month	Day	Year	3. Time of [
	/Medic	al	An English Name (If not institution		Slendora	a V. Le	e 4b. City, Town, or L	continue of Dooth		Sep 5, 200		6:00 p	
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or E	ocation or Death. Baltir		4C. Count	y of Death N	' Δ	
	Funeral		5. Social Security Number	Long Greel		. last birthday)		If Under 24 Hrs.	8. Date of Birth	n		place (State or	Foreign
	Director		216-68-5102	1□M 2√DF	48	8 Yrs.	Months Days	Hours Min.	(Month, Day May 17		_	ntry) Naryland	
	p ,		Usual Residence of Decedent							, , , , , , ,			
	anyta shov	'n	10a. State 10b. Count		10c. C	ity, Town or Lo		imara				10d. Inside City 1 X Yes	
	28a-1	Director	Maryland 10e. Street and Number	N/A				imore		10g. Citizen of	What Cou		
	with B or		1731 Appleton Stre	at			10f. Zip Code	21217		rog. Citizeri or	U.S.A		
	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show after Examinant be notified at	Funeral	11. Marital Status	12. Was De	ecedent Ever in l	J.S. 13. V	Vas Decedent of His f Yes, specify Cuban		ecify Yes or No-	14. Ra	ce - Ameri	can Indian,	
9	or Itan		1 ☑ Never Married 2 ☐ Ma	ried 1 🗀 Yes	Forces? s 2 √ No				Rican, etc.)		ck, White,	etc.	
2	ral', c	d by	3 Widowed 4 Divorce	d If Yes, (Year or	Dates:		I□Yes 2∏x No	Specify:		Speci	^{fy:} [3lack	
ל	72 h "natu	Completed	15. Decede (Specify only high	nt's Education ast grade complete	d)	16a. Deced (Give	lent's Usual Occupat kind of work done du DO NOT use retired)	ion iring most of work	ting	16b. Kind of E	Business/In	dustry	
51215-0036	within ane. than	ld III	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. I		loyee		Sv	veet He	art Cup	
	be filed within 72 ho ital Hygiene. ed othar than "natur evant, II. M. dic.		17. Father's Name (First, Middle	Last)			•	18. Mother's Nam	e (First, Middle,	Maiden Suma	me)		
<u>a</u>	should be ind Mental I marked o	To Be	ı	lenry Lee					Cather	ine Ande	rson		
Maryland		-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	g Address (Street ar	nd Number or Rui	al Route Numbe	r, City or Town	, State, Zij	Code)	
_	and 2 salth a n 27 is		Catherine Anderson	Mother		17	31 Appleton S	treet Baltimo	ore, Marylar	d 21217			
altimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal fro		Place of Dispo cemetery, cren	sition (Name of natory or other place,)	Date	20c. Location	- City or To	own, State	
Ē	Pages ment of tant: If it		`4 □Donation 5 □ Other (Specify)		Arbut	us Memorial Pa	ark	09/10/05	Balti	more, N	/laryland	
Rai	permit. Pages Department of I Important: If its any injury or o once.		21. Signature of Funeral Service	Licensee	Wals	Per 22	. Name and Address Estep Bro	thers Funer	al Service	d 04047			
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that	it caused the dea	ath. Do not ent	er the mode of dying,	aw Place, B such as cardiac	or respiratory an	est,		Approximate Interval Betw	øen
	Pnysician		Immediate Cause (Final disease or condition				Small C					Onset and D	eath
	/Medical		resulting in death)		to (or as a conse		34717	200	SCONE	-			
	Examiner	L	Sequentially list conditions,	b. Due 6									
2	ped lisit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2 Due 1	to (or as a conse	quence or):							
 /	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c	to (or as a conse	quence of):					-		
8/60,	e be e	dical		d.									
9	tificate ig physi as the l	0	(C										
X Q	the death certific y the attending p iched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregree birth 2 Fet		Ectopic pregnancy				ate of deliv	- ,	
	e deat	sicia	in the past 12 months?		gnant at time of		Other (specify)		·	М	onth	Day Ye	ear
J.	res that the de signed by the a be detached f	Phy	9 □ Unknown Part II. Other significant condit			outing in the w	adarbina asusa suur	in Boot I	220 Did to	bacco use con	utributo to t	ho cause of de	ath?
ŝ	The law requires that ite has been signed b page 2 should be deta	l by	Hypertus		deall but not re	isulting in the u	idenying cause giver	i ii raiti.		es 2 No		/	
Š	w require been si should b	Completed	Fidberacis										
Vital Records,	ne lav has ge 2	mpl							24a. Was a autop perfor	sv	prior to co	ppsy findings a impletion of car	use of
Ö		e Co	25. Was case referred to medic	al				Of Place of Dead		med? 2 NoX	1 🗆 Yes	2□ No X	
	ysicia is cert direct	0 8	examiner? 1 ☐ Yes 2 🗶 No	Hospital:	Inpatient 2	☐ ER/Outpatien	Other	26. Place of Deat	ome 5 🗆 Resid		her (Specia	6v)	
101	ding Phys h. After this funeral di	n; T	27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time of		at	28d. Describe h			,,	
Š	tandin death. tor: Afi the fur	atlo	Z () / (OO) QOI II	igation	omin, bay rour,	ii ija.y		es 2□No					
UIVISION	al or Attandii safter death. I Diractor: Al d in by the fu	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 200. Fld	ice of Injury - At I	home, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rura	al Route Numb	er,
	spital or ours afte seral Dir filled in		200 Contil	Dhurisis T	No. 1.			<u> </u>				A-A- d	
	Hos Fur ely	edical	29a. Certifier 1 ☑ Certify (Check only one)	Examiner: On the	the best of my kr basis of examin anner stated.	nowledge, death nation and/or inv	n occurred at the time vestigation, in my opi	e, date and place, nion, death occur	and due to the d red at the time, o	ause(s) and m late and place,	anner as s and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifi	er			29c. License	number	2	29d. Date signe	ed (Month.	Day, Year)	
	1				MI		550	9056		4/7/	05		
	H		_	who completed ca	use of death (Ite			1			2.5	2	
			31. Date filed (Month, Day, Yea	claje Mi		nature &	cut ht	Royal +	ادر بحدا	C14 +12	2121	/	
	Sta Registi		SEP 0 8	2005	. Registrar's Sign	- FOR	E.						

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of learning	lealth a Death		giene	005	29281
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
	/Medic		Ralph Lawrence					August	30,	2005	1:20A M
	Examin	ier	4a. Facility Name (If not institution, give s 838 Lannerton Road)	4b. City, Town, o		Death		ounty of Death .timore	
	Funeral		5. Social Security Number 6. Sec		ge (In yrs. last birthda)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of Bir		9. Birth	place (State or Foreign
	Director			M 2□F	64 Yrs.	Months Days	Hours	4 Hrs. 8. Date of Bir (Month, Da 1 1 / 04 / 1	940	Ohio	ntry)
	Dug.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or t	ocation					fod lasids Circlinia
	Maryla 1 sho	ō									10d. Inside City Limits 1 ☐ Yes 2 🔂 No
	the 7	Director	MD Baltimore 10e. Street and Number	3	Middle Ri	Ver			10g. Citize	n of What Cou	
	23e o		838 Lannerton Road	Ē		21220			U.S.A		
	r deal	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of I	dispanic Origi an. Mexican.	in? (Specify Yes or No Puerto Rican, etc.)	- 14	. Race - Ameri Black, White,	
36	rs afte	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	No	1□Yes 2∏No	Specify:		S	pecify: Whi	
9	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "neturel", or Items 23e or 28e-f show event, the Medical Examinat must be notified at	ted !	15. Decedent's Edu	cation	16a. Dec	edent's Usual Occup	oation		16b. Kind	of Business/In	dustry
215	within 7, ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	life.	e kind of work done DO NOT use retire	during most od)	of working			•
21	filed wi Hygien other th	Con	12th		Hydra	aulic Tec					ydaulics
Maryland 21215-0036	ould be fii Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Last) Bradley Lawrence					's Name <i>(First, Middl</i> e le Moore	, Maiden Su	ımame)	
7	2 should be and Mental is marked eumatic ev	P _C	19a. Informant's Name/Relationship (Ty.	pe. Print)	19h Mai	ing Address (Street		or Rural Route Numb	er City or T	own State Zir	Code)
Ma	りたいさ		Edith Marie Lawre					Middle Rive			_ '
Jre,	ss 1 and 2 of Health a litem 27 is r other trei		20a. Method of Disposition		20b. Place of Disp	matory or other pla	ce) I	Date		tion - City or To	
Ĕ	Page ment ent: If ury or		1 ABurial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Holly Hi	ll Cemete:	rý ¦9,	/3/05	Balti	imore,	MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other		21. Signature of Funeral Service License	90				Cvach/Roseo nue Rosed			
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause	d the death. Do not er	ter the mode of dyi	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metast	atic Non S	mall Cell	Lung	Cancer			Onset and Death
	/Medical Examiner		resulting in death)		a consequence of):						· ya.
		er	Sequentially list conditions, if any, leading to immediate		à conséquence or).					7	
V	d ansit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
oʻ	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
8760,	icate be executed physician and s the burial-transit	dical		l							
	n certific anding p use as	/Мес	IF FEMALE:	3c. If yes, out <i>co</i> me	of programmy					-	
Вох	atte	Physiclan/Me	in the past 12 months?		2 Fetal death 3	□Ectopic pregnanc □ Other (specify)	y		230	 Date of delive Month 	ery Day Year
o.	that the de ad by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
ď.	S 5 0	by P	Part II. Other significant conditions con	tributing to death b	out not resulting in the	inderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
ord	w require been sig should b	ted						¹\;\bar{X}`	Yes 2□	No 3 ☐ Prob	ably 4 Unknown
O	as b	Completed						24a. Was	SV	24b. Were auto	psy findings available impletion of cause of
_	Thate ate							perfo	rmed? 2 X No	death?	2 🗆 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		at all post of		of Death Check on c			
o	Phys or this oral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ∐ Inpatio	ry 28b. Time	III 3 DOA	4 LI Nurs	sing Home 5 Resid	dence 6 2	Other (Specificcurred	Hospice
<u>o</u>	Attending r death. ector: After by the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly Year) Injury		rk? Yes 2.⊟No	0			
Division	r Atte er de recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	jury - At home, farm, si	reet, factory, office		28f. Location (S City or Tox		iumber or Rura	I Route Number,
	itel or rel Dire			1							
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 ★ Medical Examin	sician: To the best ner: On the basis of and manner st	of my knowledge, dea of examination and/or in ated.	th occurred at the til evestigation, in my o	me, date and pinion, death	place, and due to the occurred at the time,	cause(s) an date and pla	d manner as si ace, and due to	tated. the cause(s)
	To the within 2 To the comple(Ž	29b. Signature and title of certifier	nn		29c. Licens				igned (Month,	Day, Year)
			Dan			D548	41 		8/30/0	05	
	16		30. Name and address of person who co	•		•	~	000			
	Sta	te	Ashkan Bahrani 31. Date filed (Month, Day, Year)	32. Realistr	Philadelph ar's Signature		Suite	208 Rose	dale,	MD 21	237
	Registr		SEP 0 8 200	5 Alexen	w & A	rede					

State of Maryland / Department of Health and Mental Hygienes 1 - State Registral 29282 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** LEIBOVITZ MARTIN 4250 pm 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LEVINI DALE GERIATLIC, 2434 W. Belvedere BALTIMORE BALTIMORE | Honder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10/20/1926 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 78 354-18-2417 Director IL Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Yes 2 No Director 7 is marked other then "netural", or items 23e or 28e-f treumatic event, the Madical Experiment natal to notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 POMONA NORTH #2 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No WW I I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POSTAL MANAGER HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H ages 1 and 2 should be at of Health and Menta : If item 27 is marked ပ SAMUFL LEIBOVITZ ROSE KAUFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 POMONA NORTH #2 - BALTIMORE, MD 21208 SHARNA LEIBOVITZ / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HEBREW YOUNG MENS 09/07/2005 WOODLAWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine burial-transit CEREBRO VASCULAR ACCIDENT Due to (or as a consequence of): Physiclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 2 No of Vital 1 Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 [] Homicide within 24 hours a

To the Funerel C

completely filled 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier Sluston H. Wrotestenoy 10063327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) di WOLDEHIWOT, W. BELVEDERE AVE. BALTMO, M.D. 21215 2434 31. Date filed (Month, Dav. Year) 32 Registrar's Signature State 8 2005 Registrar

E BOVITZ, MARTIN

				artment of Health and Me rtificate of Death	•	ne
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Donald Martin Sr. 4a. Facility Name (If not institution, give street and number) Harbor Hospital Center			Day 2005 3 Firm of Beautiful 2005 9:48 pm 4c. County of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217 24 1019 1 X M 2 F 77 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth Month, Day, Yea Jan. 10,	17) 1928 9. Birthplace (State or Foreign Country) Maryland
	ter death with the Maryland liems 23a or 28a-1 show trectives be notified at	Director	10a. State 10b. County 10c. City, Town or Lo Maryland Anne Arundel Baltim 10e. Street and Number		10g. (10d. Inside City Limits 1 ☐ Yes 2 🎛 No Citizen of What Country?
36	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Jical Exaction of the notified at	by Funeral D	1 Never Married 2 Married 1 Ves 2 No	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- can, etc.)	U.S. 14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	d within giene. r than "	Completed b	15. Decedent's Education (Specify only highest grade completed) [Secondary (0.12) College (1.40x 5+) Flementary (Secondary (0.12) College (1.40x 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) ice Officer	7	Kind of Business/Industry
ryland	should be filed nd Mental Hygi marked other imatic event, I	To Be	17. Father's Name (First, Middle, Last) Walter Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailit	18. Mother's Name (i Ruth ng Address (Street and Number or Rural i	Hanse1	,
	ss 1 and 2 of Health a ltem 27 is		Mary A. Martin / Wife 522 (20a. Method of Disposition 1	Old Riverside Road Date of the matory or other place)	Baltimo	ore, Maryland 21225 Location - City or Town, State
Baltimore,	permit. Page Department of Important: If any njury or once.		21. Signature of Funeral Service Licensee 22	ren Mem. Park 9/6/20 2. Name and Address of Facility GOI 4001 Ritchie Highway	nce Funer	en Burnie, Maryland al Service, P.A. ore, Maryland 21225
	Prysician /Medical Examiner		Due to (of as a consequency of):	011	respiratory arrest,	Approximate Interval Batween Onset and Death 12 hours
68760,	ate be executed thysician and the burial-transit	lical Examiner	Sixuality let out the control of a first leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 6	that the death certificate to by the attending physic detached for use as the b	Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	The law requires that the ate has been signed by the bage 2 should be detache	ed by PI	Part II. Other significant conditions contributing to death but not resulting in the un Bowle Schemia	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
al Records,	i: The law ri icate has be r. page 2 sh	Completed by	Acute respiratory failure		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death. 1 □ Yes 2 □ No
Division of Vital	ttending Physician: The lav death. ctor: After this certificate has the funeral director, page 2.	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 No Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			6 □Other (Specify) ury occurred
Divis	or A lifter Direction by	Il Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) 29a. Certifler 1 ☐ Certifying Physician: To the best of my knowledge, death		City or Town, Sta	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	at the time, date ar	nd place, and due to the cause(s)
	2011		30. Name and address of person who completed cause of death (Item 23a) (Type, Seyed Morieza Farasat, M.D. 3001 3 31. Date filed (Month, Day, Year) 32. Registrats Signature	Print) S. Handler St R. Hin	Sep nove Mi	1/225
	Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 0 8 2005	Assol	111	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29284 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** Month 2005 September 7:45 Marie Mendelis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Nov. 12, 1906 Mary I and 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 √ F 218-46-4748 Director 98 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD Baltimore Parkville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ permit. Pages 1 and 2 should be filed within 72 hours after death w. Department of Health and Mental Hygiens. I filem 27 is marked other than "natural," or items 23e eny injury or other traumatic avant the 8800 Walther Blvd. #3506 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: δ 3 ☐ Widowed 4 ☒ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Vincent George Waskevich Magdalene Bobinas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann Marie Schwartz / daughter 635 Eliot Road: Pasadena, MD 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 9/8/05 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer & Service LL 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD 21204 auc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and ched for use as the burial-transit Due to (or as a consequence of) Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death 1 ☐ Yes 2 No Records, P.O. 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probebly 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: $_4$ Nursing Home $_5$ Residence $_6$ Nother (Specify) HOSPICE ٩ 1 ☐ Yes 2 😿 No 3 DOA this After this To the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated

SEPTEMBER

ANNA MENDELIS

Vital

ō

Division

State Registrar

DR. TARIQ MAHMOOD

29b. Signature and title of certifier

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

05

29c. License number

00072	riease Type of Fillit in Diack indelible link. Effsute All
alph Eli Moxley Jr.	State of Maryland / Department of Health and Me

-P			For State Registrar	State of M	arytand / Dep <i>Ce</i>	ertificate of		nentai Hyg R	eg. No. 200	5 29285
	Physici	0.00	Decedent's Name (First, Middle	, Last)				2. Date of Deat Month		3. Time of Death
	Physici /Medio		Ralph Eli Moxl					Septemb		
1	Examir	er	4a. Facility Name (If not institution	_		4b. City, Town,	or Location of Death		4c. County of	
			University Of M			Baltimo				more City
Ŀ	Funeral Director		5. Social Security Number 216-26-7119	6. Sex 7. Ag	e (In yrs. last birthday 67 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-7-19	, Year)	Birthplace (State or Foreign Country) MD
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f-e	Funeral Director	MD Anne	Arunde1	Glen Burn	nie				1 ☐ Yes 2X No
	or 28	ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	it Country?
	23a	aic	1207 Saunders	Way		2106	1		U.S.A.	
	en de	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-		American Indian, White, etc.
Maryland 21215-0036	permit. Pages t end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show way houry or other treumatic event, the Mudical Exactions must be notified at ance.	þ	1 ☐ Never Married 2 【X Marr 3 ☐ Widowed 4 ☐ Divorced		No 1956- 1962	1 ☐ Yes 2 【XNo		, , , , , , , , , , , , , , , , , , , ,	Specify:	White
9	72 ho	Completed	15. Decedent (Specify only highes	's Education	16a. Dece	dent's Usual Occu	pation during most of work ed)	via a	16b. Kind of Busin	ess/Industry
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7	or th	Son	12			house Se	lector		Warehous	se
멀	a Hy I oth	Be (17. Father's Name (First, Middle,	Last)			18. Mother's Nam			
yla	ould b Ment Marked	To	Ralph Eli Moxl	•			Adeline	e Heward		
Jar	2 sh and Is m	. 17	19a. Informant's Name/Relations			_	t and Number or Rur			
	fealth m 27 her t		Mrs. Carmella	Moxley / wif			s Way, Glo			1061
0	t of H If ite or ot		20a. Method of Disposition / X Burial 2 Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre		I		20c. Location - Cit	y or Town, State
Ë	men tant: jury		4 □Donation 5 □ Other (S)				ery 9-9-2			Park, MD
Baltimore,	permit Depar Impor eny in		21. Signature of Fun va. Service		1177.21		ess of Facility Sin	-		
			232 Part 1 Enter the disease or				Ave SW, G			Approximate
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. Mul		junes				Interval Between Onset and Death
	netr Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
68760,	ificate be executed g physicien and as the burial-transit	ledical Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
	artifica ing ph e as th		IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed tto hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	f delivery Day Year
rds, P	w requires that s been signed b should be deta	þ	Part II. Other significant condition	ns contributing to death b	ut not resulting in the t	underlying cause gr	ven in Part I.	23e. Did tob		te to the cause of death? Probably 4 Unknown
Vital Records,	The law re ate hes bee page 2 sho	Completed						24a. Was ar autops perform 1X Yes 2	v prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No
Ħ	ian: rtifica ctor,	Bec	25. Was case referred to medical				26. Place of Deat			
<u>></u>	Physician: r this certific ral director,	To	examiner? 1 ⊊ Yes 2 □ No	Hospital: 1 ☐ Inpatie	ont 2 ER/Outpatie	nt 3 DOA	ner: 4 Nursing Ho	me 5 Reside	nce 6 Other (Specify)
o uo	Attending Pl		27. Manner of Death 1 □ Natural 5 □ Pending 2 ★ Accident investig			Wo	ry at rk? Yes 2 No	28d. Describe ho	w injury occurred me tercy	cle overfamel
É	oi or Atter efter dea I Director d in by the	Certification:	3 Suicide 6 Could r 4 Homicide determi	ot be 390 Place of Isi	ury - At home, farm, st	,		28f. Location (Str. City or Town	reet and Number o	r Rural Route Number,
	To the Hospitel or Attending Physician: The i within 24 Hours eller death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	Medical C	29a. Contilior 1 Certifyin (Check only one) 1 Medical I	g Physician: To the best Examiner: On the basis o and manner st	f examination and/or in	in occurred at the tr ovestigation, in my	me, date and place, opinion, death occur	and due to the ca	ause(s) and manne	n as stated. due to the cause(s)
	Withir To the comp	Me	29b. Signature and title of certifier			29c. Licens	se number	29	9d. Date signed (M	fonth, Day, Year)
			1/alein	1108A	5'	O.C.M	. E.	C.	antembor	07, 2005
	1		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type		T	1 20	chrammer	01, 400)
	1		ZABILICEA.	7H 44	111 Penn	Street, 1	Baltimore,	Marylar	nd 21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature			-		

DHMH 17 Rev 1/2001

Registrar

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		4	For State Registrar	State of Ma	ıryland / Depa <i>Cei</i>	artment of H rtificate of I	lealth and I Death		ien 2 0 0	5 29281	6
	Dhusisi		1. Decedent's Name (First, Middle, Las	it)	·			2. Date of Dea Month	th Day	3. Time of Death	h
	Physicia /Medic		Baby Girl N	los1ey				Hugels	128,0	25 22:37	' M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	/ /	4b. City, Town, or	Location of Death	n	4c. County	of Death	
_			5. Social Security Number 6. S	KINS TIO	SITAL	If Under 1 Year	1000 If Under 24 Hrs.	O Date of Birth		O Birtheless (Gtate of Fa	-1
	Funeral Director		1	_M 2∏F / Age	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthplace (State or Fore Country)	эідп
			none Usual Residence of Decedent				16	Aug 28,	2005	Maryland	
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim	
	e Ma	ctor	MD Cecil		Elkt	on				1 □ Yes 2√	No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Country?	
	ath w	ra	5 Maple Court				1921		USA		
	ltems	une	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, k, White, etc.	
36	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examilier must be notified at	by Funeral	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 21 N If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	black	
ŏ	2 hou	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	4:	16b. Kind of Bus	siness/Industry	
21215-0036	thin 7 e. "n	ple	(Specify only highest gra	de completea) College (1-4or 5-	`life.	kind of work done o DO NOT use retired		King			
	ed wi	Son		none	none	2			none		
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Nar	ne (First, Middle, i	Maiden Sumame	»)	
<u></u>	d Mer narke	2	Dequan Cope1 19a. Informant's Name/Relationship		40h Marili	ng Address (Street a		asha D. M		G-4- 7- 0- 4-)	
Ma	d 2 st th and t7 is r treur		Johns Hopkins Ho			N. Wolfe				1287	
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of				City or Town, State	
Ö	ages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☑ Other (Specification)	Removal from State	cemetery, crei	matory`or other plac	(8)				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-1 show eny injury or other treumetic event, the Medical Examiner must be notified at one.		21 Si nature a Funeral Service Licer Renald S			2. Name and Addres					
m	F 0 F 0		incinii s.	wade, Little	ctor St	tate Anate altimore,	omy Boar MD 212	d 655 W.	Baltimo	re Street	
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Вох	h cert andin	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Testonia programav			23d. Date	of delivery	
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<u>Р</u> О	at the by the	Physician/M	9 ☐ Unknown *								
	res th	by	Part II Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause give	en in Part I.		1	bute to the cause of death?	
000	w require been sig should b	eted	TYDVANIC O	7-13				1 🗆 Ye		3 Probably 4 Unknow	
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ō	Phy or this oral d	J: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b. Time o	IL 3L DOA	4 Nursing F	ome 5 Reside			
<u></u>	uttending death. ctor: Afte y the fun	atio	1 Evatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		K? Yes 2 ☐ No				
Division of Vital	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inju	iry - At home, farm, sti	reet, factory, office		28f. Location (St City or Town		er or Rural Route Number,	
	itel or A	Cer		,							
	To the Hospitel or Attending Physicien: The law requires that the death certii within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	(Check only 2 Medical Exar	ysician: To the best of	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)	
	o the ithin 2 o the emplei	Med	one) 29b. Signature and title of certifier	and manner s	l⊎d.	29c. License	e number	2	9d. Date signed	(Month, Day, Year)	
	F ≱ F 8		1	BX	MD	IN NO	Dallal	Λ.	1CAIC+	28.760E	
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Print) \	101420	\sim 1	MAN 21	20120	
			Rener DE	POSS WD	600	N. Molt	te st.	Balt	nor 1	rangland	
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	_	. Decedent's Name (First, Middle	le, Last)				rtificate c		401	2. Date of				3. Time of Dea
ysician Jedical	_	SELMA				M	OSHI N SK	Y		Month SEPTE		Day ER 4	Year 2005	2:04
kaminer	48	a. Facility Name (If not institution					4b. City, Town	n, or Loca	ation of Deat				ty of Death	
	5	SINAL MOSPIN. Social Security Number	6. Sex	F 39		MONE last birthday)	BA 1 If Under 1 Ye		Inder 24 Hrs.	8. Date of	Dieth		O. Dietho	N/A
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_142	_	Jsual Residence of Decedent			10a Cii	h. Town sell-							1	
r items 23e or 28e-f show		MD BALTIMORE				10c. City, Town or Location							1	0d. Inside City Li 1 ☐ Yes 2 5
	10	10e. Street and Number			BALTIMORE 10f. Zip Code					10g. Citizen of What Country?			<u>'</u>	
	1	1500 BEDFORD AVENUE #414			21208								USA	
Fune		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Forces 1 Yes 2 West Pear or Dates:			If Yes, specify Cuban, Mexican, Puer			Specify Yes or No- rto Rican, etc.)			14. Race - American Indian, Black, White, etc. Specify: WHITE			
Experiment of the state of the	-				1 ☐ Yes 2 ☒ No Specify:									
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	17	7. Father's Name (First, Middle,	Last)					18. N	Mother's Nan	ne (First, Mid				
	2	MICHAEL				FISH			CLARA					KLINE
	1	19a. Informant's Name/Relations LEONARD HORWI		•			ng Address (Stree ENNY LA					ty or Town 2120		Code)
	20	0a. Method of Disposition	·		20b. F	Place of Dispo	sition (Name of		DALII	Date ,	-		- City or To	wn, State
iry or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Ϫ Remov: <i>pecify)</i>	al from State	- 1		natory`or other p A CEMET		09/0	7/2005	i UF	PFR	DARBY	- PA
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MOSHINSKY, SELMA

State of Maryland / Department of Health and Mental Hygiene 1- State Regis AMEND ITEM #10b PER FH C847 9/93/14/15/24/19 of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2005 Melvin Nash, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakland Hospital 0akland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F 217-18-6344 **Director** 85 Oct.12,1919 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or Items 23a or 28a-f shov the Madical Examiner must be natified at Carrol1 1 ☐ Yes 2 ☑ No Funeral Director Maryland Carrett Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21074 331 Shamer Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 GYes 2 □ No If Yes, Give Year or Dates: Ţ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Be Completed by 3 XWidowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) bricklayer building Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 Is marked other t ijury or other traumatic event, IL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William H. Nash Mamie H. Sholz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 331 Shamer Lane, Hampstead, Maryland 21074 Melvin Nash, Jr. - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 9/14/2005 Baltimore, MD 21. Signature of Funeral Service L Importa eny inje 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician I wee /Medical Due to (or as a consequence of). Examiner ear hipema Sequentially list conditions, if any lading to immunate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) o 9 Unknown of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Their disin 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No င္ 1 Impatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Dine of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ↑ Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 [Homicide Hospitel within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ares 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 8 2005 Registrar

State of Maryland / Department of Health and Mental Hygien 005 29289 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Concetta Rose Nolker 4, 2005 September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 6505 Glenoak Avenue If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 👿 F 93 Director 217-03-9286 Usual Residence of Decedent December 23. Marvland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event, Tra Modical Examinat must be notified at 2008. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** Maryland N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21214 U.S.A. 6505 Glenoak Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Rosa Scalco Vincent Farace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 Wintergreen Place Baltimore, MD 21237 Patricia Meisel-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck 5305 Harford road Baltimore, MD.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death)

25. Name and Address of Facility Leonard J. Ruck 5305 Harford road Baltimore, MD. Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford road Baltimore, MD. 21214 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physiclan/Medical Examiner inding physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Mulloc 1 Yes 2 No 3 Probably 4 Dunknown 24a. Was an 24b. Were autopsy findings available autopsy performed death? 2 🗆 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 🗌 Yes 2 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Tatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determin 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print) 14 QiCiO State 2005 Registrar

			For State Registrar	State of Man		epartment of I Certificate of			ene2005	29290
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	/Medic Examin		4a. Fecility Name (If not institution, given	re street and number)			or Location of Death		4c. County of Death	
			12110 Tullamore C	t.			onium		Baltimor	
-	Funeral			I M 2 D.E	In yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	lace (State or Foreign itry)
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	and w	Ì	10a. State 10b. County	10	Oc. City, Town	or Location			1	0d. Inside City Limits
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	r 28s	rec	10e. Street and Number			10f. Zip Code	-	10	g. Citizen of What Cour	ntry?
	3a o	Funeral Director	12110 Tullamore	e Ct.		2	1093		USA	
	deati	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Americ Black, White,	
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	21		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		~				Onset and Death
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DIVISION	al or At s after d it Direct id in by	Certificati	4 Homicide determine		r - At home, farn (Specify)	n, street, factory, office		City or Town	eet and Number or Rura , State)	a Moute Number,
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State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER 1 2005 THOMAS WILLIAM ORCUTT 10:25A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESAPEAKE HOSPICE HOUSE LINTHICUM ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 6/17/1941 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F 64 079-32-5594 Vrs Director Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location If item 27 is marked other than "neturel", or items 23a or 28e-1 show or other treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MD Glen Burnie Anne Arundel Directo 1 ☐ Yes 🏖 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 736 Hyde Park Drive 21061 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "neturel", or Ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No white þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Analyst N.S.A. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence W. Orcutt Doris L. Lacey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Hyde Park Drive, Glen Burnie, MD 21061 Mrs. Kathleen R. Orcutt/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State T Burial 2 N Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. Chesapeake Cremation 9/3/2005 Stevensville, MD ' 4 ☐ Donation 5 ☐ Other (Specfty) 21. Signature of Funeral Service Litensee 22. Name and Address of Facility Singleton Funeral Home P.A. M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** 8 NGS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records. P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ned by the atten a detached for u 2 Fetal death 3 ☐ Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 \square Nursing Home 5 \square Residence 6 \overline{X} ther (Specify) H (SP \overline{ICE} 1 ☐ Yes 2 Ø No 1 🗌 Inpatient 2 T FR/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Injury 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of burns cause of death (Item 23a) (Type, Print) OLITEME 32 Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 8 2005 Registrar

			1 - For State Registrar	State of Maryland /	Department of Health and Certificate of Death		2000	29292
	Physic /Medi		1. Decedent's Name (First, Middle, Last	Pear.		2. Date of Death	Day Year	3. Time of Death
	Examination Funeral Director		4a. Facility Name (If not institution, give 5. Sodial Security Number 6. Security Number 10 Usual Residence of Decedent	14 ME	4b. City, Town, or Location of Dea Walter State of Teach Control of Dea Withday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min	8. Date of Birth	4c. County of Death	nplace (State or Foreign untry)
21215-0036	be filed within 72 hours after death with the Maryland hal Hygiene. sd other then "neturel", or items 23a or 28a-f show event, it e Medical Examinational by notified at	leted by Funeral Director	10a. State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Crivorced 15. Decedent's Edu (Specify only highest grad	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: cation a completed) 10c. City, Tow	10. Zip Code 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 Yes 2 I'No Specify: Decedent's Usual Occupation (Give kind of work done during most of wo	ipecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: DA	nican Indian, a, etc.
Maryland	should and Mer s marks	To Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) RODEN 19a. Informant's Name/Relationship (Ty	College (1-4or 5+) (1) (2) (2) (3) (4) (5) (6) (7) (7) (7) (7) (7) (7) (7	ife. DO NDT use retired) 18. Mother's Nai 18. Mother's Nai 19. Mailing Address (Street and Number or Ru	me (First, Middle, Maide 5 QR55 ural Route Number, City	N	ARE ip Code)
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38760,	cate be executed / Medical / Medical Examiner : the burial-transit	dlcal Examiner	23a. Partiveties the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence of	of):	or respiratory arrest,		Approximate Interval Between Onset and Death YEAVS
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Division	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	O	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 29a. Certifier 1 ☐ Certifying Physical Certi	28e. Place of Injury - At home, far building, etc. (Specify)	death occurred at the time, date and place	28f. Location (Street ar City or Town, State	e)	
	To the Hi within 24 To the Fu complete	Medical	(Check only 2 ☐ Madical Examinone) 29b. Signature and title of certifier	er: On the basis of examination and and manner stated.	29c. License number	red at the time, date and	d place, and due to	Day, Year)
	V		30. Name and address of person who con **RANCIS X ST 31. Date filed (Month Pay Veer)	RAIN, III, LI	Type, Print) SO ST Pace	2 BACK	- MO	21202
	Sta Registra	_	SEP 0 8 2005	32 Registrar's Signature	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 For State Registres Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Ball Plunkert Yvonne **Physician** Priscilla 2:20a September 6 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 20 Birthplace (State or Foreign Country)
 Md 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1964 Months Hours 1 M 2 X F 41 212-86-4914 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a State ral, or items 23e or 28e-f show Examiner must be notified at Carroll Westminster Md 1X□ Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 48 Pennsylvania Avenue USA Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white If Yes, Give 12 Year or Dates: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic svent, it a Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If item 27 Is marked other tha any injury or other traumatic event. Ital. once. homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Ball Loretta Harding 19a. Informant's Name/Relationship (Type, Print) George Warren Plunkert (spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Pennsylvania Ave., Westminster, Md 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Sykesville, Md All County Cremation | 9-8-05 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Duige Haight Sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonia 2 weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Multiple Examiner Sequentially list conditions, if any, leading to immediate cause. Extend outlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ^o 1 ☐ Yes 2 ☐ MG 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: / 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 52035 2005 Sep och 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

291

32. Registrar's Signature

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SEP 0 8 2005

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31. Date filed (Month, Day, Year)

2/157

Westminister

		For Amend	Item 8 per	Manyland / De	370272006 Sertificate of	Health and Mo Death	ental Hygier Reg. (29291
	N)	Decedent's Name (First, Midd	lle, Last)				2. Date of Death		3. Time of Death
Physicia	_	WILLIAM	1	B.	Rosen	BERGER		Day Year 7, 2005	- 6:00 PM
/Medica		4a. Facility Name (If not institution		ber)		or Location of Death		4c. County of Deat	
	*	814 5.	Currey	Street	BAL	+ IMORE			
ineral		5. Social Security Number		. Age (In yrs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreig
ector		212-60-7522	1 M 2 □ F	52 Yr	s. Nortals Bays		10/30/195		ARY PAND
	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r I ocation				10d. Inside City Limit
arather trast be netified at	2	Toa. State	f		4				1 XYes 2 □ N
哥	Director	MARYANDI		BATT	10f. Zip Code		10-	Citizen of What Co	
3	늅	10e. Street and Number	2	1-0	Toi. Zip Code	12011	109.	U.5.	
188	era	11. Marital Status	RLey S.	lent Ever in U.S.	13. Was Decedent of I	Hispanic Origin? (Spe	city Yes or No-	14. Race - Ame	
IIAC	Funeral	1 Never Married 2 Mai	Armed Ford	es?	If Yes, specify Cub	an, Mexican, Puerto F	Rican, etc.)	Black, White	
Exam	by §	3 ☐ Widowed 4 ☐ Divorce	If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	Uhite
99		15. Deceder	nt's Education	16a. D	ecedent's Usual Occu	pation	16b	. Kind of Business/	Industry
Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4	·	give kind of work done fe. DO NOT use retire	ed)		BeB	PRODUCE
event, Ine M	E O	12	oomege (1	P	roduce	SALCSMI	AN	P - D	FRODUCE
vent	Bec	17. Father's Name (First, Middle				18. Mother's Name	(First, Middle, Maid	fen Sumame)	a
tic e	To	WILLIAM	J. Ko	SCNBCR	6 er	MyR	tle	1+	unt
		19a. Informant's Name/Relation			failing Address (Street	t and Number or Rura	l Route Number, Cit	y or Town, State, 2	Zip Code)
othar traumatic ev		HNDRA KOSEN	BERGER - S	Spouse 8	14 5, C	The second second second second second	rect D	Alto-1	1021224
	- 1	20a. Method of Disposition 1 D Burial 2 Premation	2 Domewal from S	comoton	isposition (Name of crematory or other pla			Location - City or	
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any injury o		21. Signature of Funeral Service	e Licensee	-	22, Name and Addr	ess of Facility A	NNINOLI	censed,	Morticin
any i		1 (harles	2 Jan		P.O. BOY	23942	BAIto.	MARYLA	NB 21203
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	complications that car	used the death. Do not	enter the mode of dy	ing, such as cardiac o	r respiratory arrest,		Approximate Interval Between
ysician //ledical		Immediate Cause (Final disease or condition	i	IVER E	Anw RE				Onset and Death
		resulting in death)	Due to (c	r as a consequence of)					
ner		O	h //	MATTAT	76 00	weren	AC CA	NEW	
4	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du to (o	r as a consequence of)					
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		resulting in death) Last	Due to (o	r as a consequence of)	•				
<u> </u>	dicai		d						
2	O I	IF FEMALE:		,					
for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live bir	ome of pregnancy th 2 ☐ Fetal death	3 ☐ Ectopic pregnand	гу		23d. Date of del Month	ivery Day Year
detached 10	Sic	1 🗆 Yes 2 🗆 No 9 🗆 Unknown	4□Pregna 9□ Unknov	nt at time of death wn	5 ☐ Other (specify) _				,
	Phy	Part II. Other significant condit	tions contributing to de-	ath but not requising in "	a underhine cours	ven in Pa≠1	23e Did tabasa	n use contribute to	the cause of death?
			OINTESTIVI		1	TOTAL CALL	1 ☐ Yes		
should	ompleted	0,77(18	1-10-111	1- 3000	7		-		
CI.	nple						24a. Was an autopsy	prior to	itopsy findings availab completion of cause of
0	Con						performed		21 No
rector,	Be	25. Was case referred to medic examiner?				26. Place of Death	(Check only one)		
0	2	1 Yes 2 No	-	patient 2 ER/Outp	atient 3L DOA		ne 5 Residence		cify)
neu	on:	27. Manner of Teath 1 ZNatural 5 □ Pend	28a. Date of (Month	f Injury 28b. Tin , Day Year) Inju	ıry Wo	ork?	28d. Describe how in	njury occurred	
the fi	Certification:	Accident inves 3 Suicide 6 Could	tigation]Yes 2 □No	201 1 1 10		
n by	E		mined 286. Place of	of Injury - At home, farm g, etc. <i>(Specify)</i>	i, street, factory, office	4	28f. Location (Street City or Town, St	tate)	urai moute Number,
led								<u> </u>	
ely fi	Medical	(Check only 2 Medica	ing Physician: To the t I Examiner: On the bas	sis of examination and/					
completely filled in by the fu	Med	one)	and manne	er stated.	29c Licen	se number	29d	Date signed (Mont	h Day Year
Ö	=	29b. Signature and title of certification of the control of the certification of the certific	AS (MO)						
		I CONTIN				17934	120	A (COND)	x 8, 200
		30. Name and address of person	\	- 57		MB AI	go m		
		V. COM	u > M	Sol Si	PAR PC	100	ULO NUT	400	
Sta		31. Date filed (Month, Day, Year		gistrar's Signature					
Registr	ar	SEP U	8 2005	Garage H	A Second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29295 For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 9:19 AM **Physician** Kichardson 2005 Fronta september /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** a. Hospita Kandalstown
H Under 1 Year | H Under 24 Hrs. 8. 0 Center Northwest 8. Date of Birth (Month, Day, Year) 1/13/1971 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 1 F Min. Days Hours Md Director 10c. City, Town or Location 10d. Inside Gity Limits 10a. State 27 is marked other than "netural", or Items 23a or 28e-f show treumatic event, the Modical Examination ust be notified at 1 Yes 2 No Director Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2911 Woodland Ave. 21215 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital/Status Black, White, etc. ges 1 and 2 should be filed within 72 hours after it of Health and Mental Hygiene. If item 27 is marked other than "netural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LLNK Unemployed

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie Ann Gibbs Donald Joseph Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2911 Woodland Ave. Baltimore, Md. 21215 Ernestine Johnson injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Importent: If iten
any injury or oth 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8710 dogwood Rd, Windsor Mill King Memorial Park9/10/2005 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lewis T. Gwynn Funeral Home 21. Signature of Funeral Service License 4517 Park Heigths Ave Balt. Md. Luis 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple organ system

Due to (orlas a consequence of): **Physician** failure disease or condition resulting in death) /Medical **Examiner** usternic inflammatory response Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine signed by the attending physician and does detached for use as the burial-transit bacteremio positive Due to (or as a consequence of): P.O. Box 68760 Substance abuse Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. / Protein energy malnutrition 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Anemia of chronic inflammation 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Rhabdomyelysis 25. Was case referred to medical 1 ☐ Yes 2 ☐ No Acute pancrectitis Vital To the Hospitel or Attending Physicien: Be (26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manyler of Death After Injury 1 Natural Division 5 Pending 1 Yes 2 No death. investigation 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28462 GOSTON MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Randallstown, Maryland Northwest Hospital 32 Registrar's Signat 31. Date filed (Month, Day, Year) State SEP 0 8 2005 Registrar

			1 - For State Registrar	ate of Maryland		rtment of H		Mental Hy	giene 0	05	29296
	Physici /Medic		Decedent's Name (First, Middle, Last)	Seatrice	R	alex	P	2. Date of De Month	nher 6	Year 2005	3. Time of Death 7:40 HM
	Examin		4a. Facility Name (If not institution, give stree	and number)	enter	4b. City, Town, or	Location of Death	1018	4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. Sex 225−16−8964 1□ M	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Feb 16	rth ay, Year)	9. Birthpl Count Mary	lace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		Town or Loc	ation			1 12 10		Od. Inside City Limits
	sa-f sh	Director	Maryland n/a	Balt	timore						1. Yes 2 No
	a with th	I Dire	10e. Street and Number 3320 Benson Avenue			10f. Zip Code 21227	7		10g. Citizen of United		•
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1	Vas Decedent Ever in U.S med Forces? ☐ Yes 2 M No Yes, Give	lf	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert		14. Rad Bla	ce - America ck, White, e	an Indian, etc.
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nd	be filed tal Hygi d other svent, I	Be	17. Father's Name (First, Middle, Last)		200,21		18. Mother's Nam		, Maiden Sumar		1011
Maryland	2 should be and Mental Is marked a	ဥ	Frank Fisher 19a. Informant's Name/Relationship (Type, F	Print)	19h Mailine	Address (Street a		Ziegle		State 7in	Code
	1 and 2 s Health an tem 27 ls		Donald Paul Pittman			rails En					
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Remo	vai ii oiii Çialo		ition (Name of atory or other place	1	Date	20c. Location		
altim	artmen ortant: injury	1	* 4 □ Donation 5 □ Other (Specify) 21. Signatyfe\of Funeral Service\(\text{Licensee}\)	New	Cather	Iral Ceme Name and Addres	etery 9/1	0/2005	Baltim	ore, M	Maryland Inc
ä	permit. Departi Import any inj	0 19	1 Unn 4 3	nk)7 Wilker					
	Priysician	1	23a. Part 1. Enter the disease, or compleate shock, or heart failure. List only one call immediate Cause (Final disease or condition	ns that caused the death.	Do not ente	1-1-	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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8760,	ate be executed hysician and the burial-transit	dical	d					***			
.O. Box 6	death certific e attending p od for use as	Physician/Mec	in the past 12 months?	yes, outcome of pregnan □Live birth 2 □Fetal o □Pregnant at time of dea □Unknown	death 3 🗆 8	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year
S, D	w requires that the s been signed by th should be detache	by	Part II Other significant conditions contributions of the significant conditions contributions are significant conditions.	ting to death but not resul	ting in the un	derlying cause give	n in Part I.	23e. Did t	_	tribute to the	e cause of death?
Division of Vital Record	aw 1s b 2 s	Completed	anemia					24a. Was autor perfo	osy ormed?	prior to com death?	osy findings available appletion of cause of
Vita	Physicien: r this certific ral director.	Be	25. Was case referred to medical examiner?	al:		3C DOA Othe	26. Place of Dea	th (Check only o	one)		
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Sior	Attendin death. ctor: Af y the fur	icatlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y	es 2□No	29f Logotion (Street and North	nos os Oussil	Davie Mumber
Ο̈́	rs after al Directed in by	Certification:	4 Homicide determined	le. Place of Injury - At hor building, etc. (Specify)	ne, iaini, stiei	at, lactory, office		City or To	Street and Numb wn, State)	rei oi nuiai	Adule Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	edical	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	, and due to the rred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
}	To To Com	Σ	29b. Signature and title of certifier	my M	D	29c. License	JJ3	Q1 -	entem	1 0	Day, Year)
	2		30 Name and address of person who completed the second sec	to Suse of death (Item:	23a) (Type, P	rint)	altim	ere l	Varyl	omd	21227
1	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 2005	32. Registrar's Signatu	ire	de)			-1		

Michael Roche 05-05989 RPD

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

9909		For Unperstate Registrar	end Ite	em 23	State of	28a	yland / f per	Depa Tile Cer	utmen tificate	501년 e of L	ealth a Death	nd M as	lental Hy	giene Reg. No	200 	15	29297
-		1. Decedent's Nam											2. Date of Do			'ear	3. Time of Death
Physicia /Medica		Michael	J. Ro	che			-						Septem			005	1953 P ^M
Examine		4a. Facility Name (eet and nu	ımber)			4b. City,	Town, or	Location o	Death		1	. County of		
		Northwes	t Regio	onal	Hosp	ital			Rand	alls	town			I	Baltin	ore	
Funeral Director		5. Social Security N 213-92-		6. Sex	M 2□F		In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	ff Under 2 Hours	Min.	8. Date of Bi (Month, D July 1	av, Year		Coun	ace (State or Foreign ry) land
p >		Usual Residence o 10a, State	f Decedent 10b. County				IOc. City, Tov	wn or Lo	cation							10	od. Inside City Limits
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with Be or		6917 Rich		venue	9				Toi. Zip	2124	44			_	Unite		,
	by Funeral	11. Marital Status 1 Never Man 3 Widowed		ried	2. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2 💽 No live		1	Vas Decec f Yes, spec l □ Yes	ify Cuba	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	14. Race Black,	White, e	etc.
72 hour			15. Deceder	nt's Educa	ation	111	168	(Give	dent's Usua kind of wo DO NOT us	k done d	luring most	of work	ng	16b. h	Kind of Busi	ness/Ind	ustry
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permit. Depertuimport import eny inj		21. Signature of	uneral Service	Licensee	Zil	rk							bard Fi Balt				Inc. nd 21229
		23a. Part1. Enter	the disease, o	complic	ations that	caused t	ne death. Do								C) 1341	yıu	Approximate Interval Between
Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final on	a.	Naro	cotic	-		and	A1co	hol I	ntox	icatio	n			Onset and Death
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acuted ind transit	Examin	if any, leading to it cause. Enter Under Cause (Disease or that initiated event resulting in death)	5	c .													
cate be executed physicien and the burial-transit	dicai E	rossaming an ossum,		d.		Or as a	consequence	e (II).									W
ng pt	Ψ	IF FEMALE:															
To the Hospital or Attending Physician: The law requires that the death certification at hours efter death. To the Funerei Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No	23	1 Live	birth 2 nant at ti	pregnancy Fetal deat me of death		Ectopic pr Other (sp	,					23d. Date Monti		ry Day Year
w requires that been signed b should ba deta	<u>۾</u>	Part If. Other signi	ificant conditi	ons cont	ributing to	death but	not resulting	in the u	nderlying c	ause give	en in Part I.			tobacco Yes 2		ute to th	e cause of death? ably 4 Unknown
sicien: The law req certificate has beel lirector, page 2 shou	Completed	<i>1.</i>											24a. Wa auto perf	opsy ormed?	pri de	or to con atb?	osy findings available npletion of cause of
tifice tor, p	0	25. Was case refe	rred to medica	al .							26. Place	of Death	(Check only			5-	
ysician: iis certifii director,	0	examiner?] No	Ho	spital:] Inpatien	2 🛛 ER/C	outpatien	t 3□ D0	Oth	er: 4 🗆 Nu	rsing Ho	me 5□Res	idence	6 Other	(Specify)
oding Phys th. : After this of stuneral dir	tion: T	27. Manner of Dea 1 Natural 2 Accident	5 Pendi	ng igation	28a. Date (Mo.	nth, Day		Time of Injury	unk 2	8c. Injun Worl	/ at		28d. Describe				-
To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the to	Certification;	3 Suicide 4 Homicide	6 Could deter	not be nined	28e. Plac	ce of Injur	y - At home, (Specify)	farm, str	eet, factor	, office			28f. Location City or To	wn, Stat	^(e) 6917	Ric	Route Number, hards Ave.
Hospite 24 hours Funere	Medicai C	29a. Certifier (Check only one)			cien: To the	ne best of	xamination a						and due to the ed at the time	cause(s) and man	ner as st	ated.
To the within 7	Me	$-\Delta I$	d title of certific	er	<u>N</u>				290	. License	e number			29d. Da	ate signed	Month, I	Day, Year)
		30. Name and add	tress of persor	who con	npleted car	use of de	ath (Item 23a) (Туре,		.C.M	ſ.E.			Se	tembe	r 2	2005
-04		31. Date fifed (Moi	ON L	ocke	= U	Pagaistrar	11. 's Signature	l Pe	nn St	reet	, Bal	timo	ore, Ma	ry1a	and 21	201	
Stat Registre			SEP 0 8		4	ROLLA	B	A	ede	•							

			State of Maryland / Der State of Maryland / Der State Amend Item 10d, f, 3 per FH	Reg. No. 2005 2929								
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year Unknown								
	/Medic	al	John Lawrence Swats	August 5, 2005 4b. City, Town, or Location of Death 4c. County of Death								
	Examin	er	4a. Facility Name (If not institution, give street and number) 6706 Pine Grove Drive	Morningside Prince George								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)									
	Director		579-56-5654 1XM 2□F 62 Yrs.	April 15, 1943 Washington, D.								
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation 10d. Inside City Limi								
	Marylan f show	ō	Maryland Prince George Mornings	ide								
	r 28e	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?								
	th with	alD	6706 Pine Grove Drive	20746 U.S.A.								
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene item 27 is marked other than "neturel", or items 23e or 28e-f show other treumatic event. The Medical Examinat must be indiffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Native Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Native Married 1 Never Married 2 Native Married 1 Never Married 2 Native Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 2 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 3 Never Married 4 Never Marr	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify: Specify: White								
8	2 hou eture cal E	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of working 16b. Kind of Business/Industry								
21215-0036	thin 7 e. an "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)								
	filed wi Hygien other th	Co	12 Plum	ber Greenbelt Homes 18. Mother's Name (First, Middle, Maiden Surname)								
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ms	Be	17. Father's Name (First, Middle, Last)	Petrel A. Zeller								
Ž	should ind Men marke umatic	2	John Swats 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
<u>⊠</u>	ulth ar 27 is r treu			Columbia Rd. Woodbridge, Virginia 22191								
nore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 in eny injury or other tre		Jesse L. Simmons, Brother 1302 Columbia Rd. Woodbridge, Virginia 22191 20a. Method of Disposition 1									
Baltimore,	permit. P Departme Importen eny injur.		21. Signature of Faneral Service Licensee	22. Name and Address of Facility 4143 Dale Blvd. Mountcastle Funeral Home Dale City, VA 22193								
ALC: N	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Approximate Interval Between Onset and Death								
x 68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	224 Date of delivery								
.O. Box	that the death certific hed by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	□ Ectopic pregnancy Other (specify)								
<u>α</u>	w requires that sbeen signed b should be deta	by	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
Il Records,	(0 -	Completed	Uninsured	24a. Was an autopsy findings availat prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No								
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case ref_rred to medical examiner?	26. Place of Death (Check only one)								
ō	Phys this ral di	.T	27 Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28d. Describe how injury occurred								
on	ding Ph th. After th funeral	tlon	1 Tratural 5 Pending (Month, Day Year) Injury 2 Accident investigation									
Division	after death. after death. I Director; After d in by the fune	ertifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director; completely filled in by the	Medical Certification;	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de a manner of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
)	To the To the comp	W	29b. Signaturand title of certifies	29d. Date signed (Montel, Day, Year) 29d. Date signed (Montel, Day, Year)								
	&		30. Name and address of parson who completed cause of death (Item 23a) (Type County Samuel Sa	2 Anvapolis Rd Hyatsville MD								
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 8 2005									

EM	00074		Please Type or Print in Black Indel	lible lnk. Ensure All	Copies Are	e Legible.	
dd:	5-06074 ie Sins	1et					29299
			State of Maryland / Depart 1- State Unpend Item 23a,27,28a-1 per me G84 Registrar Amend Item 5 per fh G848 Certifi	cate of Death 10-7-	-05 tas _{leg.1}	No. 2003	27277
	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Death September)ay 5 2/9a(5	3. Time of Death 10:43 Ам
	/Medi Examii			LETARY City, Town, or Location of Death		4c. County of Death	
1	LAGIIII	iei		Baltimore City		N/A	
e X	Funeral Director		112-44=3394. 112 M 2□F 59 Yrs. Mo	Under 1 Year If Under 24 Hrs. Entry Days Hours Min.	8. Date of Birth (Month, Day, Yea APRIL 01,/	9. Birthplant 946 MA	ace (State or Foreign
9	/land		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n		10	Od. Inside City Limits
	a-f sh	tor	MARYLAND N/A S	ALTIMORE	CITI		1 Yes 2 No
	or 28	Dire	10e. Street and Number	Of. Zip Code	/0g. 0	Citizen of What Count	ry?
	eath v	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was l	2/22	5	U5A	1.2
က္	after d or item	Fun	Armed Forces? If Yes 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	Decedent of Hispanic Origin? (Spec s, specify Cuban, Mexican, Puerto Ri	ican, etc.)	14. Race - America Black, White, e	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural; or iteme 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Yes 2 No Specify:		Specify: 32	9CK
15-("natt	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of working IOT use retired)	16b.	Kind of Business/Indu	ustry
2121	filed within Hygiene.	omp	Elementary/Secondary (0-12) College (1-4or 5+)	SHORE MAN		BOOK	
	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maide	en Sumame)	/
Maryland	ould be Mental Marked c	T0	ROBERT SINGLETAK	21/ EDN.	A	HUDS.	ON
Mar	d 2 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	deress (Street and Number or Rural)	Route Number, City	or Town, State, Zip (Code)
	Health Tem 27 other tr	1 8	20a. Method of Disposition 20b. Place of Disposition	Name of Dai	te 20c.	Location - City or Tow	MD, 2/208
Baltimore	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	y or other place)	9-05 %	3 AN TIMOR	EMA
alti	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Nar	me and Address Facility	POWN ICT	R. FUNE	en Home
	80E # 8		which N. William 21	40 N. FULTON	AVE., 2	BALTO, M.	0,21217
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac or i	respiratory arrest,	1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Methadone)	intoxication			
	Examiner		Due to (or as a consequence of):				
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Вох	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ Ecto	pic pregnancy		23d. Date of delivery	/
	at the dea by the at stached fo	sici		er (specify)		Month D	ay Year
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of	Physic rthis ral dir	٠ <u>.</u>	1 Yes 2 No Hospital: 1 Inpatient 2 EF/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of			6 Other (Specify)	
ion	or Attending F ifter death. Director: After in by the funer.	Certification:	1 Natural 5 Pending Found: M	Work?	d. Describe how inj	ury occurred U	ink
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ā	itel or irs aft ral Dir led in	Cert	Found: Residence		altimore	City, Mary	lylew Koad, land
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investige and manner stated.	irred at the time, date and place, and ation, in my opinion, death occurred	d due to the cause(s at the time, date ar	s) and manner as stated and place, and due to the	ed ne cause(s)
	To the within 2 To the complet	Σ	29b. Signature and file of certifier	29c. License number		ate signed (Month, Da	
,		1	The state of the s	OCME	56	eptember 6	, 2005
			30. Name and address of person who cominated cause of death (Item 23a) (Type, Print)	enn Street Baltim	ore Mars	7land 2120	L
	Sta		31. Date filed (Month, Day, Year) 31. Registrar's Signature	Au Sciece Darelli	ore, mary	- I GIT GIT GIT GIT GIT GIT GIT GIT GIT G	
	Registr		31. Date filed (Month, Day, Year) SEP 0 8 2005				
DH	MH 17 Rev 1/20	001					

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2 0 0 5 For State Registrar 29300 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Gertrude E. Searcy September 6:30 A. M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Millennium Nursing Home Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year June 3, 19 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Yrs. 81 Ohio 287 20 8193 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1843 West Pratt Street U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 XVidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 10th College (1-4or 5+) Machine Operator Maryland Envelope traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I pe Genevieve Allen Jesse Hagaman permit. Pages 1 and 2 should to Department of Health and Ment Important; If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Searcy / son 704 Matthews Avenue Baltimore, Maryland 21225 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ō ` 4 ☐Donation Loudon Park Cemetery 9/6/2005 5 Other (Specify) Baltimore, Maryland Injury 21. Signal e of Funeral Service Liden 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that cause. The disease, or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each instance. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? to Month Year Day 4□Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. þ 128310 1 ☐ Yes 2 ☐ No 3 ☐ Probably MUnknown Completed been Seull 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Yes 2 No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Tes Certification: To 2 No ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number person who completed cause of death (Item 23a) (Type, Print) AVESTEZ31 ANNAPOLIS, MD. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

P.O. Box 68760.

Division of Vital Records,

			1 - For State Registrar		State of	Marylan		artment o <i>rtificate</i>			d Men		iene	05	29301
20	Physici /Medi		Decedent's Name (First, Manuels Bernard Samuels	iddle, Last)								nate of Death	Day	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution Sinai Hospital	ution, give st	reet and num	iber)		4b. City, To	wn, or Loc		eath	4	4c. County	W.V.	
	Funeral Director		5. Social Security Number 217–40–2268		M 2□F	7. Age (In yrs. 1	last birthday) 1 Yrs.	If Under 1 Y	ear If	Under 24 I	lin. (A	ate of Birth Month, Day, 2-09-19		9. Birthpl Count Mary l	lace (State or Foreign try) and
	show	,	Usual Residence of Deceder 10a. State 10b. Co MD			10c. City	y, Town or Lo				<u> </u>			10	0d. Inside City Limits 1 XYes 2 □ No
	h the M or 28a-f	Director	10e. Street and Number	IVA				Baltimo				10	g. Citizen of W	hat Coun	
	ath wit	rai D	1 Catoctin Ct. A						2123				USA		
036	urs after de al', or itams	by Funerai	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Divo	Married	2. Was Dece Armed For 1 TYYes If Yes, Give Year or Da	2 🗆 No	1	Vas Decedent f Yes, specify l□Yes 2X		nic Origin? lexican, Pu pecify:	(Specify) lerto Rican	Yes or No- n, etc.)			etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be collified at once.	Completed	(Specify only h.	- 1	ation completed) College (1-	4or 5+)	(Give life. I	lent's Usual O kind of work o OO NOT use r	ccupation lone durin etired)	n ng most of	working	1	6b. Kind of Bu	siness/Ind	B lack lustry
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ylan	ould be Mental Mrked c	To Be	Clarence Bates							Lor	raine	Sar	muels		
Mar	ath and the an		19a. Informant's Name/Related Alice M. Samuels		e, Print)			g Address (Si Coctin Cl					City or Town, S	State, Zip	Code)
more,	Pages 1 ar		20a. Method of Disposition 1 XBurial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		moval from S	tate	lace of Dispo emetery, cren	sition (Name of natory or other	of r place)		Date	2	Oc. Location - (•	
Balti	permit. I Departm Importa any injui		21. Signature of Funeral Ser			Gali	22	. Name and A	ddress of	Facility	13-05 8 N.Gi		Owings Mi t. Balto,	100	
50, A	Physician / Medical Examiner st the prival-transit	Examiner	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	Due to (c	or as a consequent as a conseq	Mujo Couence of):	andic	Λ	was care	0		st.		Approximate Interval Between Onset and Death 45 w. s.
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Reco	elaw hasb je 2 sł	Completed			00						-	4a. Was an autopsy perform ☐ Yes 2[ed?/ pr	or to com	sy findings available upletion of cause of
Division of Vital Records,	ng Physicien: fter this certific ineral director,	Certification: To Be C	3 ☐ Suicide 6 ☐ Co	Но	28a. Date of (Month) 28e. Place of		ER/Outpatien 28b. Time of Injury me, farm, stre	28c.	Other: 4 Injury at Work? 1 Yes	□ Nursing	Peath Che Home 5 28d. D	ock only one S Residen Describe how	nce 6 Other	(Specify) d	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 V Cert (Check only one)	fying Physical Examine	cian: To the b	is of examinati	wledge, death ion and/or inv	occurred at the	ne time, d my opinio	ate and pla	ce, and du	ue to the cau	use(s) and man be and place, ar	ner as sta	ted. the cause(s)
	To the within To the comple	Me	29b. Signature and little of cer	tifier	~			29c. Lic	ense nur	mber		290	d. Date signed	(Month, D	lay, Year)
			· iann	M	M.				00	1217	30		Sept	06	5 2005
	5		30. Name and address of per	ion who com	pleted cause		23a) (Type, I	Print)					4		
Section 8	Sta Registr		31. Date filed (Month, Day, Y	ear)	32. Re	gistrar's Signat		ante							

	ľ	1 - For State Registrar		warytand	Certi	ficate of L	Death	d Mental Hy	Reg. No.	005	29302
Physici /Medic		1. Decedent's Name (First, Middle			Sha	ppee		2. Date of De Month	+ 19	, 2005	3. Time of Death 1929 M
Examir Funeral	ner	4a. Facility Name (If not institution The Johns H 5. Social Security Number	opkins H	ber) OSPITA . Age (In yrs. Ias	st birthday)	b. City, Town, or Caltimeter 1 Year Months Days	-	rs. B. Date of Bir (Month, Da	th ay, Year)		place (State or Foreign
Director		None Usual Residence of Decedent	A		115.	2 23		May 27	, 200.	5 Mar	yland
72 hours atter death with the Maryland neturel', or Items 23e or 28e-f show dical Examinant han not be molified at	7	10a. State 10b. County		10c. City,	Town or Loca					,	Od. Inside City Limits
the Ma	Director	MD Balti 10e. Street and Number	Lmore		Owing	gs Mills			10a Citizo	n of What Cour	1 Yes 2 No
3a or	I D	10810 Sherwood	4 H411				1117		rog. Okizo	USA	,
F, or Itams 2	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2	No No	If Y		spanic Origin?	(Specify Yes or No erto Rican, etc.)		Race - Americ Black, White,	
all Hygiene. It hygiene. It has "neturel", or frame 23a or 28a-f show event, the Medical Exercitive fraust be rediffed at	Completed I	15. Deceder	nt's Education est grade completed) College (1-4		16a. Deceder (Give kir. life. DC	t's Usual Occupa d of work done d NOT use retired,	ution luring most of v	vorking	16b. Kind	of Business/In	dustry
other ti		none 17. Father's Name (First, Middle,	none Last)		none		18. Mother's N	lame (First, Middle	noi Maiden St		
nd Mental markad o matic eve	To Be	David Shappe						en Depolo		,	
E 12 15	_	19a. Informant's Name/Relations			-			Rural Route Numb	-		
item 27 other tr	1	Johns Hopkins	Hospital	20h Pla	600 ce of Dispositi		Street	t Baltimo			
Department of H Important: If ite any Injury or ot once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (5	Specify) in sta	tate cer	metery, crema	ory or other place				tion - City or To	
Depar Impor any In		21. Signature of Euroral Service RONALO	b Wade	rector	-	timore,	•	rd 655 W. 201	Balt	imore S	Street
physician be exactled by physician and bhysician and bhysician and stee private transit stee	sal Examiner	Immediate Ca (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a conseque	ence of):	C With	perton	ated Vic	sas		ól4 haur
e attending d for usa as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal d .nt at time of dea	leath 3□E	ctopic pregnancy ther (specify)			230	1. Date of delive Month	ery Day Year
sigr d ba	by	Part II. Other significant conditi	ions contributing to dea	ath but not result	ing in the unde	erlying cause give	n in Part I.	23e. Díd		,	he cause of death? pably 4 □Unknown
ate h	Completed							24a. Was auto perfo		prior to co death?	psy findings available mpletion of cause of 2 \(\text{No} \)
this certificat ral director, p	Be	25. Was case referred to medica examiner?	Hospital:			2□ DOA Othe	P	eath (Check only			
After	ıtlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendii 2 Accident investi	28a. Date of	-	R/Outpatient 28b. Time of Injury	28c. Injury Work	4 🗀 Nursing	g Home 5 - Resi 28d. Describe			ý)
in Litte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place o	of Injury - At hom g, etc. <i>(Specify)</i>	ne, farm, stree	, factory, office		28f. Location (City or To	Street and t wn, State)	lumber or Rura	al Route Number,
4 hours Funere	edical C	(Check only 2 Medical one)	ng Physician: To the bast Examiner: On the bast and manner	sis of examination	on and/or inves	tigation, in my op	inion, death o	ccurred at the time,	date and pl	ace, and due to	the cause(s)
within 2 To the comple	Me	29b. Signature and title of certific	9			29c. License	number		29d. Date s	igned (Month,	Day, Year)
		Just m	1	4.0.		RES	-00	0 6	8/1	9/05	•
	11		and the state of t								
		30. Name and ad ress of person 31. Date filed (Month, Day, Year	who completed cause	of death (Item 2	23a) (Type, Pri	FE ST	. BA	TIMM	ϵ, ν	10 2	287

			1 - For State Registrar			partment of Hertificate of I		Reg.	ne No 2 1 1 5	29303
К	Physicia	an	Decedent's Name (First, Middle	, Last)			4	2. Date of Death	Day Year	5:-Time of Death
P	/Medic	al	Baby Girl S 4a. Facility Name (If not institution			Ab City Town or	r Location of Death	Myst	4c. County of Deat	14125
	Examin	er	The Tobex A	tooking HOW	2:401	1301.1.	· nai)		4c. County of Deat	11
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. last birthda		If Under 24 Hrs.	B. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
	Director		none	1 □ M 2 🔀 F	Yrs.	Months Days		Month, Day, Ye ugust 4,		aryland
	pu »	ļ	Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or	Location				10d. Inside City Limits
	shov	JG.	MD	"	Baltin					1y Yes 2 No
	the N	ect	10e. Street and Number		Darti	10f. Zip Code		100	Citizen of What Co	
	with Se or		5903 St. Roger	s Road		21206		109.		and y
	Jeath Ins 23	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 1	3. Was Decedent of H	ispanic Origin? (Spec	ify Yes or No-	USA 14. Race - Ame	rican Indian,
9	after or lite	Fur	1 🎇 Never Married 2 ☐ Marr	Armed Forces? ied 1 ☐ Yes 2 ☐ No If Yes, Give X			n, Mexican, Puerto Ri	ican, etc.)	Black, White	e, etc.
03	rel', c	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2√√ No	Specify:		Specify: b	lack
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-1 show the Next colling at the Recolling at	Completed	15. Decedent (Specify only highes		(Gi	cedent's Usual Occup we kind of work done	during most of working	165	b. Kind of Business/	Industry
121	within ane. then	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	none	. DO NOT use retired	1)	no	 .	
7	a filed of Hygie other t		none 17. Father's Name (First, Middle,	_none Last)	none		18. Mother's Name (one den Sumame)	
an	ould be Mental arked o	To Be	Joseph L. Matt						,	
Maryland	2 should be and Mental Is marked (eumetic ev	F	19a. Informant's Name/Relations		19b. Ma	iling Address (Street	Dawn Si and Number or Rural I		ity or Town, State, 2	Zip Code)
	1 and 2 Health a em 27 le		Johns Hopkins	Hospital	60	0 N. Wolfe	Street Ba	altimore.	MD 2128	37
altimore,	ss 1 a		20a. Method of Disposition	l l	20b. Place of Dis	position (Name of rematory or other place	Da		c. Location - City or	
Ĕ	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🌠 Other (S	oecify) in state	,	, , , , , , , , , , , , , , , , , , , ,				
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neture!; or items 23s or 28e-1 show any injury or other treumetic event, the Nextbell East it act must be callined at once.		21. Signature of Europeal Service Ronald		trova	22. Name and Addres	ss of Facility	655 W B	altimara	Ctraat
<u> </u>	90F 99		100000	11/1/10					artimore	Street
Ē.				complications that caused thonly one cause on each line.	e death. Do not e	enter the mode of dyin	g, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	= Extreme	- pre	naturity				23 -145
	/Medical Examiner		resulting in death)	Due to (or as a c			2			
1		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of):					
	nsit	Examiner	Cause (Disease or injury	S						
Ć.	execu n and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a c	onsequence of);					
8760,	death certificate be executed e attending physician and of for use as the burial-transit			d						
9	rtifica ng ph as th	Physiclan/Medlcal	15.55144.5							
Вох	eath certific attending p I for use as I	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		B ⊟Ectopic pregnancy			23d. Date of deli	
O. E	the at hed fo	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown		Other (specify)			Month	Day Year
Ρ.	that the de ed by the detached		Part II. Other significant condition	ans contributing to death but a	not reculting in the	underhing cause and	on in Part I	23e Did tobaco	co use contribute to	the cause of death?
ds,		l by	rait ii. Odioi signineant conditio	The continuating to death but I	iot resulting in the	underlying cause givi	en in Fan I.	1 ☐ Yes	2 ZNo 3 □ Pro	
Ö	law requires as been sign 2 should be	etec					· · · · · · · · · · · · · · · · · · ·		/	
Vital Records,	0 4 0	Completed						24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
a	(0 -	e Co	25. Was case referred to medical					1□ Yes 2		20 2 No
	Physicien: this certific ral director,	o Be	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpat	ient 3 DOA Othi	er: 4 Nursing Home	-	e 6 Other (Spec	760
of	g Phy er this eral c	\vdash	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Injury	/ at 28	d. Describe how in		any)
<u>o</u>	Attending F r death. sctor: After by the funera	atlo	1 Matural 5 ☐ Pendin 2 ☐ Accident investig		ear) Injun		Yes 2 □ No			
Division	for Attencatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could and determined		- At home, farm, Specify)	street, factory, office	28	f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,
	itel o Irs aft rel Di	Cer					h			
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical	g Physicien: To the best of r Examiner: On the basis of ex	(amination and/or	ath occurred at the tin investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause I at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	thin 2 the the	Med	one) 29b. Signature and title of certifier	and manner stated		29c. License	e number	29d	Date signed (Mg/fith	Day Year)
)	5 7 K 3		16 mics	2-13:	1	Do	12607		8/40	5
•			30. Name and address of person	who completed cause of deal	th (Item 23a) (Tun	e. Print)	1683	1	h.	
				600	n- 1	WolfE	Streat,	Dalte	MORE	Ml I/25
	Sta	te	31. Date filed (Month, Day, Year)	0 8 2005	Signature	Sperker				
	Registr	ar	ŞÉL	û o sana	Alter 1	1				

		/sician ledica amine
30x 68760,	ath certificate be executed	ttending physician and or use as the burial-transit

		Please Type or Print in Black State of Maryland / D	epartment of He	ealth and Mer	_		
Physicia	an	1 - State Registrar 1. Decedent's Name (First, Middle, Last) HERBERT LEON SMITH	Certificate of D	2.		2005 Day Year 5, 2005	3. 2m - 9 Bath [11:10a M
/Medic Examin		4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center	4b. City, Town, or Towson			4c. County of Death Baltimore	11:100
Funeral Director		212 36 9297 X 34	thday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye ar. 27,		ace (State or Foreign try) YLAND
Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD • N/A BALT	or Location			10	0d. Inside City Limits 1 XYes 2 No
with the N 3a or 28a-	Funeral Director	10e. Street and Number 5220 YORK ROAD APT. 5N	10f. Zip Code 21:	212		Citizen of What Coun	try?
filed within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or items 23s or 28s-f show ant, it a Marical Examiner must be reciliand at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Specify , Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - America Black, White, of Specify: BLA	etc.
ithin 72 houne.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done di life. DO NOT use retired)	uring most of working		. Kind of Business/Ind	
parmit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natu any injury or othar traumatic avant, If a Musical once.	To Be Col	11TH 17. Father's Name (First, Middle, Last) CLIFTON SMITH	WELDER_	18. Mother's Name (Fi	irst, Middle, Mai		ION
ind 2 shoul alth and Me 27 Is mark	ř	CALVIN N. SMITH (BROTHER) 15	. Mailing Address (Street a	OD RD. BA			Code)
Pages 1 ament of He ant: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of cemeter 20c. Method of Disposition 20b. Place of cemeter 20c. Place of cemeter 20c. Place of cemeter 20c. Place of cemeter		EMATORY ,	2005 _{BA}	LTIMORE,	
permit Depart Import any inj	L	Signature of Funeral Service Licensee 2. Signature of Funeral Service Licensee 2. Signature of Funeral Service Licensee 2. Signature of Funeral Service Licensee 2. Signature of Funeral Service Licensee 2. Signature of Funeral Service Licensee	1412 E.	s of Facility SCRUGGS PRESTON such as cardiac or re	ST. BA		21213 Approximate Interval Between
Pnysician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to or as a consequence	of):				Onset and Death
be executed sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence c. Due to (or as a consequence)					
The law requires that the death certificate be the seven signed by the attending physic page 2 should be detached for use as the bear.	Physiclan/Medical	d	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ory Day Year
law requires that as been signed be 2 should be detailed.	by	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause give	en in Part I.		co use contribute to the	
The law requir	Completed	anoxic exceptualopa hypoteusian/res	piratory	errest	24a. Was an autopsy performed	prior to cor death?	psy findings available impletion of cause of 2 340
OI VITAL Phyaician: This certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes Hospital: Inpatient 2 EP/Oil 27. Manner of Death 28a. Date of Injury 28b.		4 Indianing Frome		e 6 Other (Specify	v)
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be 28e, Place of Injury - At home, fix	Injury Work	<br Yes 2 □ No	. Location (Stree	at and Number or Rura	d Route Number,
Spital or /	ai Certi	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the tim	ne, date and place, and	City or Town, S	se(s) and manner as si	lated.
To tha Hc within 24 I To tha Fu completel	Medical	(Check only one) 2 Madical Examiner: On the basis of examination are and manner stated. 29b. Signature and title of certifier	29c. License	number		Date signed (Month,	
٩		30. Name and address of person who completed cause of death (Item 23a)	7 4:0	2005	Pari I	to Mn	>
Sta Regist	ate rar	31. Date filed (Month Day, Vear) SEP 0 8 2005 32. Fightrar's Signature	Shoult)	- 3			
	V	7	The same of				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey 30 Yvette Desiree Tate ก็ร็ 8 1:10 Pm 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 10504 West Wood Drive Che1tenham Prince Georges 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) 09-07-61 9. Birthplace (State or Foreign Days 1□ M 2 F Months Hours 577-84-5066 43 Yrs WashingtonDO Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Prince Georges Che1tenham 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10504 West Wood Drive 20623 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Police Official D.C. Police Dept. 17. Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harrison Anderson, Sr. Delores Jesse 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tate (spouse) 10504 West Wood Dr., Cheltenham MD., 20623 Robert L. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1X Burial 2 ☐ Cremetion 3 ☐ Removal from State Fort Lincoln Cemetery 9/7/05 Brentwood, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 420 H Street N.E., Washington DC., 20002 M01178 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) _a Leiomyosarcoma Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 ☐ Yes 2ONo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify) 1 ☐ Yes XXNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b Time of 28d. Describe how injury occurred Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

Physician /Medical Examiner Box 68760, certificate be P.O. Division of Vital Records, Attending Physician: daath. within 24 hours after daath.

To the Funeral Director: A completely filled in by the fu ò

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

parmit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or Item only Injury or other traumatic event, the Medical Examina

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

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Certification:

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funeral

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signed by

with the Maryland

death

State

Registrar

31. Date filed (Month Day, Year) SEP 08 2005

29b. Signature end title of certifier

(Check only one)

32. Redar's Signeture

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

ORIGINAL

Charles Boice, MD 2001 Medical Parkway, Annapolis, MD. 21401

29c. License number

29d. Date signed (Month, Dey, Year)

September 2,2005

DHMH 16 Rev 6/95

			For State	State of Maryland / Department of Health and Mental Hygien Certificate of Death	05 29306
			Registrar 1. Decedent's Name (First, Middle, Last	2. Date of Death	3. Time of Death
	Physici /Medic	al	4a. Facility Name (If not institution, give	street and number) 4b. City, Town, or Location of Death 4c. Cour	nty of Death
1	Examin	er —	3831 White	Avenue Baltimore.	
	Funeral Director	,	5. Social Security Number 6. Se	x 7. Age (In yrs. last birthday) If Under 1 Year 1 Under 24 Hrs. 8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
	ow at	0	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. inside City Limits
	sa-f sh	Director	MD	Baltimore	1 Yes 2 □ No
	h with ti	al Dire	3831 A Shife	Avenue 21206 10g. Citizen o	of What Country?
	er deat Items	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	lace - American Indian, lack, White, etc.
9036	hours after death with the Maryland tural', or Heme 23a or 28a-f show al Exartimet must be notified at	d by F	1 Never Married 2 Married 3 Widowed 4 Divorced	Yes 2 □ No 1 Yes, Give 1 □ Yes 2 No Specify: Year or Dates: Spec	sity: Black
21215-0036	in 72 h n "natu Wedles	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secoptar) (0-12)	16a. Decedent's Usual Occupation 16b. Kind of 16b. Kind of 16c. College (1-4or 5+) 16c. DO NOT use retired 16b. Kind of 16b. Ki	Business/Industry
	filed within 72 Hygiene. Hher then "nei ht, the Medic	Com	17. Father's Name (First, Middle, Last)	Security Guald 18. Mother's Name (First, Middle, Maiden Sum.)	Spital
Maryland	should be tind Mental I	To Be	Smith Twee	dy Gussie Twee	del
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic svent, the Medical Examinat must be notified at ance.		19a. Informant's Name/ e ationship (7)	ype, Prit) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow	m, State, lip Code)
ore,	Pages 1 ar nent of Hea ant: If Item ary or other	1	20a. Method of Disposition Disposition 2 Cremation 3	20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location	n - City or Town, State
Baltimore	permit. Pa Departmen Important: any Injury once.		* 4 ☐ Donation 5 ☐ Other (Specify, 21. Signatore of Funeral Service Licens	700700	Services
Ä	permii Depar Impor any Ir		13/1 Cl7	THOS LOCKED Balto MD	21212
ı	Physician		shock, or heart failure. List only of Immediate Cause (Final	lications that caused the death. Do not enter the mode of dylig, such as cardiac or respiratory arrest, ne cause on each line.	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	120005
		ner	Sequentially list conditions, in any, leading to initial diatocause. Enter Underlying Cause (Disease or injury	b. — Oue-to (or sets consequence of):	
V	axecuted and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	
8760,	icate be executed physician and s the burial-transit	dical		d	
Box 6	eath certific attending p	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 23d. E	Date of delivery
	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	Month Day Year
s, P.O.	res that the signed by be detact	by Ph	Part II. Other significent conditions co		ontribute to the cause of death?
Records,	w require been si should b	eted		1 □ Yes 2 □ √0	
Rec	siclan: The law certificate has t irector, page 2 s	Completed		24a. Was an 24b autopsy performed?	b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital	Physiclan: this certificatal director.	Be	25. Was case referred to medical examiner?	26. Pface of Death (Check only one)	
of	Phy this ald	n: To	27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Location 6 DO 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28b. Time of Injury 4 Work?	
Division	Attending or death. ector: Atterby the fune	catlo	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	There or Pum Pouta Number
Div	s after al Direct of in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nur City or Town, State)	iber of Aufai Addie Namber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and riner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	manner as stated. e, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		ned (Month, Day, Year)
•			1 Damy 1 Per	Dertey 05/260 09/0	12100
_	7		30. Name and address of person who d	ompleted cause of death (Item 23a) (Type, Print) wells mb 225. Greene St-Buttiwill MID 2/12	-01
K	Sta Registi		31. Date filed (Month Pay Year) 2	Shelf MD 225. Greene &- Buttimile MD 2/2	

			1 - For State Registrar	State of M	aryland / De	partmer ertificat	t of H	ealth a	and M		gier 2 () Reg. No.	05	2930	07
	Physici	an	1. Decedent's Name (First, Middle, Last Ella Lo) Ouise	Thatche					2. Date of Dea	Dav	Y <i>e</i> ar	3. Time of D 8:30A	
	/Media	cal	4a. Facility Name (If not institution, give				Town or	Location o	of Death	Septem	ber 1,	2005 ty of Death		IVI
	Examir	ier	9603 Michael Dr				linto		Dogui				orge's	
	Funeral		Social Security Number 6. Se		ge (In yrs. last birtho	ay) If Under	1 Year Days	If Under 2 Hours	24 Hrs.	8. Date of Birt	h		place (State or ntry) Dama	Foreign
	Director			M 20 F 7	5 Yrs					Dec. /	1929	Alat	pama	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City	Limits
	Mary a-1 sh	to	Maryland Prince Ge	orge's	Clint	on							1 ☐ Yes	No No
	or 28;	Olrec	10e. Street and Number			10f. Zip					10g. Citizen o		•	
	s 23a	ral	9603 Michael Drive				207					U.S.A		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-1 show important: If item 27 is marked other than "healtest Examinat must be rediffied at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Yes 2 11 Yes, Give Year or Dates:	>	I3. Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	Spec	ace - Ameri ack, White, ify:		
5-0	72 ho natur	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. De	ecedent's Usu	al Occupa	ation during most	of workii	na l	16b. Kind of	Business/Ir	ndustry	
121	within ine. ihan "	mpl	Elementary/Secondary (0-12)	College (1-4or	- fin	e. DO NOT u	se retired)		.9		Home		
d 2	filed v Hygie ther t	ပ္ပိ	12th 17. Father's Name (First, Middle, Last)			по	memal		r's Name	(First, Middle,	Maiden Suma			
an	lid be lental ked o	To Be	Alexander Vander	built Poo	1e				tula		Webs	•		
ary	shou and N is mai		19a. Informant's Name/Relationship (T			-				l Route Numbe	-		•	
	and and sealth m 27 har tra		<u> </u>	r (Husban						nton Ma				
Baltimore,	it of H it of H it ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		20b. Place of Dicemetery,			10	ept.	2,	20c. Location			
ΞĒ	artmer ortant injury		'4 ☐ Donation 5 ☐ Other (Specify,		Lee Cr	emator 22 Name at			2005		Clinton			
Ba	permit Depar Impor any in once.		1/1/1/1/1/1/1/a	h 1700	153	6633 0°	ld Al	evand	, Lee Iria	Funera	al Home	inton	, MD 20	7735
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each I	d the death. Do not ine.	enter the mod	de of dyin	g, such as	cardiac o	r respiratory ar			Approximate Interval Betwo Onset and De	reen
8760,	certificate be executed rding physician and se as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):	•	ark	cins	0 N.	s di-	cease			
O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _f					1	ate of deliver	*	ear
of Vital Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death t	out not resulting in th	e underlying o	cause give	en in Part I.		23e. Did to	~	ntribute to t 3 □ Prot	he cause of dea bably 4 ∐Un	
000	as on Ci	Completed								24a. Was		. Were auto	opsy findings av	vailable
Ä	9 4 9	mo								autop perfor	med? 200 No	death?	mpletion of cau 2 X No	Tise of
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					-	of Death	(Check only o				
of \	Physician: this certific ral director,	10 10	1 ☐ Yes 2 XNo 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji				4 1901	rsing Hon		lence 6 □O		fy)	
on	fter ine	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	iy Year) 200. Till	ry M	28c. Injun Worl 1 □ 1	rat ∢? Yes 2 □ñ		28d. D <i>e</i> scribe h	iow injury occi	urrea		
Division	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, farm tc. (Specify)				2	28f. Location (5 City or Tow		nber or Rura	al Route Numb	er,
	he Hospit in 24 hours he Funera pletely fille	edical	one)	sician: To the best iner: On the basis of and manner si	of my knowledge, d of examination and/d ated.	eath occurred r investigation	at the tim	ne, date and pinion, deat	d place, a	and due to the oped at the time, o	cause(s) and r date and place	nanner as s , and due t	stated. o the cause(s)	
	With Tot com	Σ	29b. Signature and title of certifier	1.			c. License		. ^ -		29d. Date sign	ed (Month,	1	٠. ٦
			19.19a	hun.	a		J)0	052	190	14	04	101	1200) <u>U</u>
	6		30. Name and address of person who c Ali Rahimian M.D		death (Item 23a) (Ty Irratts Ro		15 C1	intor	M-	rula-1	20725		1	
		ate	31. Date filed (Month, Day, Year)		rar's Signature	<i>γ</i> αα #20	, J U L	THLOH	, ria	ryrand	20/35			
	Regist		SEP 0 8 2005	Fig. a.	Mr 1	218 1								

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 7, 2005 **Physician** Veronica Twele 5:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March , 1924 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 219-12-8401 1 ☐ M 2 🗓 F 81 Yrs. Marviand Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumetic event, the Madical Exempler must be notified at 10d. Inside City Limits MD Harford Bel Air Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ₩it 2108 Geneva Place 21015 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!, eny injury or other treumetic event, I'm Madical Exist injury or other treumetic event, I'm Madical Exist. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Baltimore City Jail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Claude Ε. Dobbs Emma G. McAleer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Veronica Carrington-daughter 2108 Geneva Place, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) New Cathedral 9/10/05 ^¹ 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Month disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760, Physician/MedIcal the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. the detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has performed? 1 ☐ Yes 2 No of Vital 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT, M.D.2300 DULANEY VALLEY ROAD TIMONIUM 21093 MD31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar 8 2005

DHMH 17 Rev 1/2001

7, 2005

SEPTEMBER

MARY

State of Maryland / Department of Health and Mental Hygien 0 0 5

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		•	1 - For State Registrar	State of Maryland	Ce	rtificate o	f Death		Reg. No.	JJ	23303
	_ 18.15		Decedent's Name (First, Middle, Last	st)				2. Date of De Month	nath Day	Year	3. Time of Death
	Physici Medic/		Edward Smith	Woollen, Sr.				Septem	ber 4, 2	2005	7:35 A M
	Examin		4a. Facility Name (If not institution, give	e street and number)			n, or Location of Death		4c. County		
3			Gilchrist Cente				wson			altin	
4	Funeral Director		212 10 4340	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Ye Months Day		8. Date of Bir (Month, Da Feb. 6	V Year)	9. Birth Cou Mari	place (State or Foreign Intry) JLand
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Manyl f ehc	5	Maryland N/A			Baltimo	re.				1 No Yes 2 No
	28e	rec	10e. Street and Number			10f. Zip Cod	8		10g. Citizen of	What Cou	intry?
	N wiff	0	6210 Birchwood	Avenue			21214		u.s	.A.	
	deaf	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	. 13.	Was Decedent of	of Hispanic Origin? (Sp Juban, Mexican, Puerto	ecify Yes or No)- 14. Rac	ce - Ameri	ican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23e or 28e-f ehow important: If Item 27 Is marked other than "natural", or Items 23e or 28e-f ehow pringing or other traumatic event, the Modical Exerting fruit its modified at once.	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1	1 □ Yes 2 💢		,	Specil		ite
5-0	72 hc	eted	15. Decedent's E	ducation ade completed)	16a. Dece	dent's Usual Oc	cupation ne during most of work tired)	ang	16b. Kind of B	Jusiness/Ir	ndustry
2	3.2 should be filed within h and Menfal Hygiene. 7 le marked other than " traumatic event, the Mas	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOTUSO 101 UNIST	tired)		Aircr	akt (70.
2	iled v tygia ther t		12th Grade 17. Father's Name (First, Middle, Last	1	Mocci	DC17057C	18. Mother's Nam	ne (First. Middle			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Maryland	d be f anfal h	Be	James Robinson						th Ble	,	7
Z	should Me mark	2	19a. Informant's Name/Relationship (19b. Maili	ing Address (Str	eet and Number or Ru				<u> </u>
	nd 2 ; alfh ar 27 le r trau		Mrs. Mary Jane Wo	ollen (wife)	6210	Birchu	ood Avenue	, Balti	more, M	D 212	214
ē,	ten of Hear Item		20a. Method of Disposition	20b. Pla	ice of Disp	osition (Name of matory or other	place)	Date	20c. Location	- City or T	own, State
E	Page nenf c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🕱 Other (Special Control of the Con	Hemoval from State	aney	Valley	Mem'l 9/8				
Baltimore,	permit. Departit Imports eny inju		21. Signature of Funeral Service Lice	nsee	2	2. Name and Ad 1705 Bel	dress of Facility Schair Rd., B	himunek altimor	Funera e. MD	L Hon 21236	nes
77.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	aplications that caused the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Chronic	N	not f	Lune				Onset and Death
3.0	/Medical		resulting in death)	Due to (or as a consequence	ence of):	www.	CITOCC				9000
de	Examiner		Sequentially list conditions	b. huper ter	15102	7					1cars
7	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to of as a conseque	ence of):						1
V	be execufed sicien and burial-transif	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):						
60,	cafe be ex physicien the buria	a E		200 10 (01 00 00 00 110							
68760	tificafe ig phys as the	Aedical	>	_ d							
Box (ndin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		□Ectopic pregna	20.00		23d. Da	ate of deli-	very
	death death ed for	Physician/I	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Other (specif)			М	lonth	Day Year
P.0	that the de ed by the e detached	Phy	9 Unknown Part II. Other significant conditions		Iting in the	underbieg enver	agues in Rod I	23e Did	tobacco use con	atribute to	the cause of death?
Ś	Se C 80	۵	Part II. Other significant conditions	contributing to death but not resu	iting in the	underlying cause	given in Part I.		Yes 2 □ No		bably 4 Unknown
9	w requires been sign should be	etec							1	1	
Records,	8 CA	Completed						24a. Was auto perf	opsy ormed?	prior to c death?	topsy findings available completion of cause of
a	ician: The cerfificefe h ecfor, page	e Co	25. Was case referred to medical				OC Plans of Dag	1 Yes		1 🗆 Yes	2 No
Ę		To Be	examiner?	Hospital: 1 Inpatient 2 E	B/Outnatie	ent 3 DOA	26. Place of Dea Other: 4 □ Nursing H	ome 5 ☐ Res		ther (Spec	in Committee
Division of Vital			27. Manner of Death		28b. Time		njury at Work?		how injury occu		"" US FICE
Ö	ndin afh. r: Aft e fur	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		1 ☐ Yes 2 ☐ No				
<u>i</u>	er de recto	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, s	treet, factory, off	ice		(Street and Num own, State)	iber or Ru	ral Route Number.
	ital or irs affe rei Dir led in										
	To the Hospital or Attervition 24 hours affer designing 24 hours affer descrote funeret Directo completely filled in by the	Medical		hysician: To the best of my know miner: On the basis of examinat and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0		29c. Lie	cense number		29d. Date sign		
			Allan	V M		D	58303		Septen	Nhes	4 2005
-	12			completed cause of death (Item	-	Print)	St rows	en ms			
ï.	St Regis	ate	31. Date filed (Momb Day, Year) 2	32/Aegistrar's Signat	ure	ark		-	1		

				1 - For State Registrar	State of Man	yland / D	epartment of I Certificate of	Health and M <i>Death</i>		2005	29310
		Physic		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month		3. Time of Death
		Physici /Medi		Clara Elizabeth				Au	qust '	29 2025	5-70 M
		Examir	ner	4a. Facility Name (If not institution, giv	<u> </u>	_	4b. City, Town, o	or Location of Death		4c. County of Death	1
				5. Social Security Number 6. S	KIVERSI		nday) If Under 1 Year	ELCAMF If Under 24 Hrs.		HARF	ORD
		Funeral Director		212-30-7756	M 2 F 72	n yrs. last birth Y	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Dec. 23,	1932 Mar	nplace (State or Foreign unity) yland
		and and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town	or Location				10d. Inside City Limits
		Maryl f sho	ō	Md. Harfo		•	Forest	Hill			1 □ Yes 2¥ No
7		1 the	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of What Cou	untry?
		h with		303F Willrich C	ircle			21050	1	U.S.A.	•
2		deat	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe	cify Yes or No-	14. Race - Amer	
-1	36	urs after death with the Marylan el', or Items 23e or 28a-f show Ezattinet i Nat Le radified at		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No		rican, etc./	Black, White Specify: Wh	, etc. nite
-	5-0036	2 5 7	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	150.0				Оросину.	
>	215	in 72 n "nat	olete	(Specify only highest gra	ade completed)	1	Decedent's Usual Occup 'Give kind of work done life. DO NOT use retire	during most of working	ng 16	ib, Kind of Business/li	ndustry
	212	d with giene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2		child care	provider		child car	re
		be filed vital Hygie od other tevent,	BeC	17. Father's Name (First, Middle, Last,)			18. Mother's Name			
A	yla		To	Rocco John Bara				1		nknown) Ba	
X	Maryland	2 = Z		19a. Informant's Name/Relationship (Eugene G. Wilso		19b. 30	Mailing Address (Street) 3F Willric	h Circle,	Route Number, C Forest H	ity or Town, State, Zi ill, MD 2!	ip Code) L 0 5 0
A	ore,	0 - = 0		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐		20b. Place of I	Disposition (Name of , crematory or other pla	D.	ate 20	c. Location - City or T	own, State
7	Ë	Page ment o tant: If jury or		`4 □ Donation 5 □ Other (Specif	y) (Gardens	of Faith	Cem. 9/2/2	005 Ba	ltimore, N	id.
U	Baltimor	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	1.000.			k Funeral			
				23a. Part1. Enter the disease, or com	plications that caused the	e death. Do no	610 W. M. ot enter the mode of dying	acPhail Ro	ad, Bel respiratory arrest	Air,Md. 2	LO14 Approximate
		Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition							Interval Between Onset and Death
	7	/Medical		resulting in death)	Due to (or as a co	onsequence of):	2.(1,03			
	н	Examiner		Sequentially list conditions.	b	<i>b</i>	diel into	an			your
	/	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of	0:1.7			1	/
	<i>V</i>	xecut and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):				
	68760,	icate be executed physician and s the burial-transit			d.		<i>,</i>				
		ificate g phy as the	edical		_ d.						
	Вох	eath certif attending for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3.05			23d. Date of deliv	rery
		deat ne attr ed for	Physician/M	in the past 12 months?	4 Pregnant at time		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	у		Month	Day Year
	P.O.	that the de ned by the a detached t	Phy	9 Unknown /							
	S,	ries th signed	by	Part II. Other significant conditions of	ontributing to death but n	ot resulting in	the underlying cause giv	ven in Part I.		co use contribute to t	the cause of death? bably 4 \(\subseteq Unknown \)
	O.C.	w requir been si should	etec	1 asu gaw	glia deger	expre	approve	· · · · · · · · · · · · · · · · · · ·			
	Rec	has l	Completed	- Mipora	117000				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
	a	i cien : The l certificate ha ector, page	e Co	25. Was case referred to medical					1 Yes 2 2		2 No
	5	yeicien: is certific director,	To B	examiner?	Hospital: 1 □ Inpatient	2□EB/Outo	patient 3 DOA Oth	26. Place of Death		e 6 Other (Speci	4.1
	o	ding Phy h. After thi funeral o		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tir	ne of 28c. Injur		8d. Describe how i		19)
	<u>i</u>	Attending I death. ctor: After y the funer	atio	1 ♠Natural 5 ☐ Pending 2 ☐ Accident investigation	1	sar/ Irij		Yes 2 □No			
	Division of Vital Records,	or Atter ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		- At home, fam Specify)	n, street, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	Ω	urs af		S 2 1/2 2	1			J.			
		To the Hospital or Attending Phyeicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/	death occurred at the tir or investigation, in my o	me, date and place, a ppinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
-		To the To the comp	ž	29b. Signature and title of certifier	111		29c. Licens	se number	29d.	Date signed (Month,	Day, Year)
		_		ex w	leur m	N	172	1975	0	x/30/05	
		5		30. Name and address of person who	completed cause of death		ype, Print) Vac Phail	ad Goo	Run 1	on 21114	1
	•••	Sta	ite	31. Date filed (Month, Day, Year)	2005 32. Registrar's	Signature	9	1,4	JAV. Jo	VI VIOI	
		Registi	ar	ATL A O	LUUJ SEE	Sal Sals	Jane.				

				Pleas	ype or Print				-	_	e.	
			For State		State of Mar	yland / Depa					r 0001	1
			Registrar			Cer	tificate c	of Death		Reg. No. 200	5 2931	
	Physicia /Medic		Betty	Lo	wise	Willy	AMS	³	2. Date of De.	5 -05	ear 3. Time of Dea	th M
	Examin	er	4a. Facility Name (If not	0.	street and number)	Hora	4b. City, Tow	Rolo 1		4c. County of	Death	
	Funeral Director		5. Social Security Number	er 6. Se		(In yrs. last bilinday) Yrs.	If Under 1 Ye Months Da	ear If Under 24 Hrs.	8. Date of Birl (Month, Da	h, Year) 9	Birthplace (State or Fo	reign
	D .	9	Usual Residence of Dec		1.	IOc. City, Town or Loc	nation				7	
	e Maryla 8a-f shov	Director	MD	o. County		Abing	LON				10d. Inside City Li 1 ☐ Yes	
0.	23a or 2		10e. Street and Number	don	Rd · AD	st. G.	10f. Zip Cod	009		10g. Citizen of Wha	at Country?	
36	within 72 hours after deeth with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Exeminer must be notified at	y Funerai		Married	12. Was Deceden Ev Armed Forces? 1 Yes 2 No If Yes, Give	er in U.S. 13. V	Vas Decedent Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puert No Specify:	pecify Yes or No o Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc.	
05 /\text{Aaryland 21215-0036}	72 hours "natural", dical Exe	eted by	3 Widowed 4	Divorced Decedent's Ed nly highest grad	year or Dates: ucation	16a. Deced	ent's Usual Oc	cupation	kina	16b. Kind of Busin	ness/Industry	>
2121	77 75 4 22	Completed	Elementary/Secondary		College (1-4or 5+)	1-60	ONOT USE TE	ne during most of wortired)		Dom	estic	
and	e da ta	o Be C	17. Father's Name (First	, Middle, Last)				18. Mother's Nar		Maiden Sumame)	ac	
Mary	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev	F	19a. Informant's Name/	Relationship (7	ype, Prin Hush	19b. Mailin	g Address (Str	eet and Number or Ru	ral Route Numbe	ar, City or Town, Sta	ate, Zip Code) 2100	9
1 -	of Health item 27 other tr	`	20a. Method o Dispositi		MS SR.	20b. Place of Dispos	sition (Name of	outa,	Apt. G	Abruga 20c. Location - Cit	y or Town, State	
9-5 altimore,	permit. Pages Department of Important: If it any injury or o		1 Burial 2 ☐ Cro 4 ☐ Donation 5 ☐ 21. Signature of Funeral	Other (Specify		Partison	Ť-	t/eneter	113/05	Ownq	Mills, M	0
Bal	permit. Departr imports any inji		21. Signature of Puneral		+	t	المنافية	500	ic Red.	Balto	MD 212	12
			23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final	ure. List only	lications that caused the one cause on each line	ne death. Do not ente	r the mode of	dying, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Deat	h
	Physician /Medical Examiner		disease or condition resulting in death)		a Due to (or as n	consequence of):	o ch	nyoar	dras	Lugare	100	4
		ner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events	ons, liate	b. Due to (or as a	consequence of):	050	Le vos	15.		109	<u> </u>
√	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		cDue to (or as a	consequence of):						
68760	cate be only siciar the buri	cai		·	d							
1400 Box 6	The law requires that the death certificate to the has been signed by the attending physic bage 2 should be detached for use as the bage 2.	Physician/Medi	IF FEMALE: 23b. Was decedent pred in the past 12 mon 1 □ Yes 2 ☑ No	ibs?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	☐ Fetal death 3 ☐	Ectopic pregna Other (specify			23d. Date of Month		
P.0	res that the de signed by the a be detached f	Phys	9 Unknown		9□ Unknown				OZ- Dida		ite to the cause of death	.2
າ ທົ	w requires the been signer should be d	ted by	Part II. Other significant	rbet	s, t	+ yre	Te 2	Cer			Probably 4 Unkn	
N B	sician: The law r certificate has be irector, page 2 sh	Completed				<u> </u>			24a. Was autop perfo 1 Yes	rmed? prio	re autopsy findings avail r to completion of cause th? Yes 2 WNo	able of
ital		Bec	25. Was case referred to	o medical	*			26. Place of Dea	th (Check only o		703 2010	
et/	> S D	P	examiner? 1 ☐ Yes 2 ☑ No			2 ER/Outpatient	3 DOA		-	lence 6 Other	Specify)	
8 io	ding P h. After funera	tion:	27. Manner of Death 1 ☑ Natural 5 [2 ☐ Accident	Pending investigation	28a. Date of Injury (Month, Day 1	(ear) 28b. Time of Injury		njury at Work? I ☐ Yes 2 ☐ No	28d. Describe I	now injury occurred		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:		Could not be determined		y - At home, farm, stre (Specify)	et, factory, offi	се	28f. Location (5 City or Tox	Street and Number on, State)	or Rural Route Number,	
)	Hospits 24 hours Funeral	ledical C	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	ysician: To the best of iner: On the basis of e and manner state	xamination and/or inv	occurred at the estigation, in m	e time, date and place by opinion, death occu	, and due to the cred at the time,	cause(s) and mannedate and place, and	er as stated. I due to the cause(s)	
Z Z	To the within To the comple	Me	29b. Signature and tile	Aratier	ALL	1 ^ -	29c. Lic	ense number		29d. Date signed (A	1.0	
	C.		30. Name and address of	of person who	ompleted cause of dea	th (Item 23a) (Type 1	Print)	. १७५५	4 -	SEAT. E	5 th 200	5
	8		31. Date filed (Month, D	. 5.	NA (R 32. Pagistrar'	M.D.		2.5.1	Hwi	rod Ko	.t.	
	Sta Registr			P 0 8 20		A A	asti I					

DHMH 17 Rev 1/2001

SEPTEMBER

			For State Registrar	State of Mai		epartment o Certificate d	f Health and of Death	Mental Hy	/giene	005	29313
	Physici	an	Decedent's Name (First, Middle, Last) MARY CATHER	INE WANZE	D			2. Date of D Month	eathDay	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s		IX	4b. City, Tow	n, or Location of Dea	09		2005 ounty of Deatl	2:00 A. M
	Cadmin	E'	FUTURE CARE L	OCHEARN			BALTIMORE			,	
	Funeral Director				(In yrs. last birth	Months Da			ay, Year) 1, 191	Co	nplace (State or Foreign untry) VA
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
	e Mar	Director	MD		BAI	TIMORE					1√ Yes 2 No
	with th	Dire	10e. Street and Number 3008 BRIGHTON	стреет		10f. Zip Cod	le 1216			n of What Co	untry?
ဖွ	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "neturel", or Iteme 23s or 28e-f show other treumatic event, Ite Marked Examiliars and the treumatic event.	by Funerai	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Evarance Forces? 1 Yes 2 M No If Yes, Give	ver in U.S.		of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N to Rican, etc.)		A Race - Amer Black, White Decify: BLA	e, etc.
Maryland 21215-0036	hours turel',	ed b)	3 X Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a. F	ecedent's Usual Od				of Business/l	
215	thin 72 e. en "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+		Give kind of work do ife. DO NOT use re	ne during most of wo	orking	TOD. Pario	01 00311033/1	ridudity
2	filed wi Hygien other th	Con	7 17. Father's Name (First, Middle, Last)			DOMESTIC	19 Mother's No	- /First & Sideli		HOME	
land	2 should be filed within and Mental Hygiene. ie marked other then eumatic event, Ine M.	To Be	WILLIE GARNER				LUCY	me (First, Middle		KSON	
ary	should that and Menter market	F	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. I	Mailing Address (Str	eet and Number or F	ural Route Numb	per, City or T	own, State, Z	ip Code)
_	l and 2 fealth a m 27 ie		ALEASE WILLIAMS/SI	STER			CON ST., B				· · · · · · · · · · · · · · · · · · ·
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of E cemetery,	hisposition (Name o crematory or other	place)	Date	20c. Loca	tion - City or 1	Town, State
atin.	artmer partmer cortent injury		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	e .	ARBUTUS	MEM. 22. Name and Ad		2/2005			
ä	permit. Departr Importe any inju		James q.	Whole	m	1701 I	AURENS ST	AMES A. REET. BA	MORTO.	N & SOI MD 21	NS F.H., INC
Г			23a Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line		t enter the mode of	dying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACe			Vascu	lax	W 6 6	iacec	(
ľ	Examiner			Due to (or as a	consequence of	usion					
/	Sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of	:					
V	xecute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of						
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	ing ph	Medi	IF FEMALE:								
.O. Box	To the Hospitel or Attending Phyeicien: The law requires that the death cert within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent premant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 Ectopic pregna 5 Other (specify			230	I. Date of deli Month	very Day Year
ds, P.	uires that signed h	by	Part II. Dther significant conditions con		not resulting in t	ne underlying cause	given in Part I.		tobacco use		the cause of death?
Division of Vital Records,	he law rec 9 has beer ge 2 shou	Completed						24a. Was auto perfe		prior to co death?	opsy findings available ompletion of cause of
ita	en: T tifficate tor, pa	Ф	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only	2√2 No one)	1 🗆 Yes	2□ No
<u>></u>	Physicien: r this certifica ral director, p	To B	1 Lies 28 110	ospital: 1 🗆 Inpatient	2 ☐ ER/Outp	atient 3 DOA	Other: 4 Nursing I	Home 5 ☐ Res	idence 6	Other (Spec	ify)
o uc	ding P		27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir Inji	iry 1	njury at Work? I □ Yes 2 □ No	28d. Describe	how injury o	ccurred	
/isic	Attender of death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury	y - At home, fam	, street, factory, offi				lumber or Rui	ral Route Number,
ă	itel or A		4 Hornicide					City or To			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 1 ☐ Certifying Phys 2 ☐ Medical Examin	ician: To the best of er: On the basis of e and manner state	examination and/	death occurred at the prince investigation, in n	e time, date and plac ny opinion, death occ	e, and due to the urred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
)	To the hwithin 2. To the Formulation	Σ	29b. Signature and title of certifier	eloumi		29c. Lic	ense number) 2674 (29d. Date s	igned (Month)	
	4		30. Name and address of person who cor ANIL UB ENC	1 1	ath (Item 23a) (T	(pe, Print) R	D BAL	70 N	10 0	11211	
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 8 201	32. Registrar	's Signature	ROLL					

		1 - For State Registrar	State of Marylar	nd / Depa		lealth and	l Mental Hyg	leg. Nd) 115	29314
Physi	cian	1. Decedent's Name (First, Middle,	Last) - A D	WIL	LENZ	•	2. Date of Dea Month FM6 U.S.	Day Year	5. Time of Death
/Med Exam		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of De		4c. County of Death	10,700
LXdii	IIICI	Hebrew Home			Rockvil	le, MD		Montgome	ry
Funera		,	5. Sex 7. Age (In yrs. 1 ☐ M 2 ☒ F	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		year) 1919 Nev	place (State or Foreign Intry) VYork
Directo	r	125-01-0031 Usual Residence of Decedent	85	115.	ll		pecember	15, 1919 Nev	VIOLK
yland		10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
e Mar	ctor	Maryland Montg	omery R	ockvil	le				1 ☐ Yes 2 X No
vith th	Dire	10e. Street and Number			10f. Zip Code 20850		1	10g. Citizen of What Cou	intry?
eath y	erai	118 Monroe Stree	12. Was Decedent Ever in U	J.S. 13.		lispanic Origin?	(Specify Yes or No-		ican Indian.
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. whar than "natural", or Itams 23e or 28e-1 show ant, the Medical Evantine or must be multified ut	Completed by Funeral Director	1 ☐ Never Married 2 ☒ Marrie	Armed Forces?				(Specify Yes or No- erto Rican, etc.)		, etc.
ours a	dby	3 Widowed 4 Divorced	Year or Dates:	sa l	1 ☐ Yes 2 🔯 No	Specify:		Specify: Cau	casian
72 h	letec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	vorking	16b. Kind of Business/Ir	ndustry
withir ene.	пр	Elementary/Secondary (0-12)	College (1-4or 5+) -3-	1	ce Admini			A.A.U.W.	
filed Hygi othar	Be Co	17. Father's Name (First, Middle, L					lame (First, Middle,	Maiden Sumame)	
Maryland 21215-0036 id 2 should be filed within 72 hours afford a constant and Mental hygiene. 27 is marked other than "natural", or traumatic event, the Medical Event traumatic event, the Medical Event traumatic event.	To B	Joseph Dollar		_		Lottie	Mettiger		
Baltimore, Maryland 21215-0036 perrit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23e or 28e-1 show any injury or other traumatic event, the Medical Event and Les multibust.		19a. Informant's Name/Relationshi	p (Type, Print)		-			r, City or Town, State, Zi	
Baltimore, Misperial Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra		Erik Willenz 20a. Method of Disposition	20h	-				ille, MD 20	
Baltimore, Derrit. Pages 1 ar Department of Hea mportant: if item		1 Durial 2 Cremation			osition (Name of matory or other place				
Itin		` 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L.		tropol:	itan Crem 2. Name and Addre	ss of Facility	Jefferson	Alexandria Funeral Ch	
B Ped Ped Single	N I	Robert	F Errans					xandria, VA	
Hope executed // Medica Examine particular and permitted in the principle of principle in the principle of principle in the principle of principle o	ı	Immediat. Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	quence of):		HOCK VAL	BLEE ,	DING	
O. Box 68 le death certifica the attending ph	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3[□Ectopic pregnancy	,		23d. Date of deliv Month	rery Day Year
cords, P.(w requires that it been signed by should be detac	ed by PI	Part II. Other significant condition	ns contributing to death but not re-	sulting in the u	inderlying cause giv	en in Part I.		bacco use contribute to les 2 □ No 3 □ Pro	,/
	Completed by	CHRONIC	LYMPHOC	YTIC	LEUX	KEMI	24a. Was a autops perfor 1 Yes	sy prior to co	opsy findings available ompletion of cause of
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or L	eath (Check only or		
Phys ral dii	5.	1 Yes 2 No	1 □ Inpatient 2 □	ER/Outpatier 28b. Time o	it 3 DOA	4 ursing		ence 6 Other (Speci ow injury occurred	ify)
Jing Afte fune	tton	1 PNatural 5 ☐ Pending 2 ☐ Accident investig		Injury		k? Yes 2 □ No		,	
Division at or Attanding setter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determin		nome, farm, st ify)	reet, factory, office		28I. Location (S City or Tow	treet and Number or Rur n, State)	ral Route Number,
Division To the Hospital or Attanumibin 24 hours effer death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the tirvestigation, in my o	me, date and pla pinion, death oc	curred at the time, o	late and place, and due t	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	fl. lan.	111 4 "	29c. Licens			29d. Date signed (Month,	
		panoen	LE KUUKER) N.T.		354 36		146451, 14	
10		BARBARIA KALI	the completed cause of death (Ite	2/ MOV	Print) VT POLE R	DAD , X	OCKVILLE	E, MD 20	2852
Regis	itate strar	31. Date filed (Month, Day, Year) SEP 0 8	2005 32. Politicar's Sign	lature	Carl .				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sept. 4.2005 **Physician** Walter Youngerman Rov /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Braddock PA 8. Date of Birth (Month, Day, Year) Dec. 8, 1932 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1ਊM 2□F Hours Months 72 168-24-8132 Director Usual Residence of Decedent the Maryland 10b Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is markad othar than "natural", or itams 23a or 28a-f shov traumatic avant, The Medical Examinatinust by notified at 1 ☐ Yes 2 ☑ No Director Maryland Prince George's Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with U.S.A. 8908 Towsend Lane 20735 12. Was Decedent Ever in U.S.
Armed Forces?

1 Pares 2 No 194
If Yes, Give Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural, or itam any injury or other traumatic avant, the Medical Exemples. 2010. Black, White, etc. 1949 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: À 1953 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) Elementary/Secondary (0-12) Refridgeration Eng. Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Youngerman Annabelle Winebrenner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen Youngerman (Son) 7607 I Street Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cometery, crematory or other place)
Lee Crematory 20a. Method of Disposition 20c. Location - City or Town, State Sept. 1 Burial 2 Cremation 3 Removal from State Clinton, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 2005 21. Signature of Funeral Service Lices 22. Name and Address of Facility Lee Funeral Home, Inc. 700153 6633 Old Alexandria Ferry RD Clinton, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Pul monary /Medical Due to (or as a consequence of): **Examiner** Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstmen're disease 1 XYes 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funaral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes ZX No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.

Inaral Diractor: After this y filled in by the funeral di Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28035 MD SA+. 5, 2005 30+1 9135 PIS MTOWAY Rd. #210 CLINTON, MD 20735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIR MOHMAD F. KOLIA. M.D.BASIRMOHMAD mo 20735 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 2005 -0 M. Joseph Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & teans this house of death (Item 23a) (Type, Print)

State Registrar

VINCENT

RAYMOND

State of Maryland / Department of Health and Mental Hygiene 2005 29317 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ΑΰĠΰSΤ Anderson Raymond Vincent 28_ 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Leonardtown St. Mary's Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**₽**M 2□F Yrs. Director 037-26-0527 88 Marcg 29,1917 Massachusetts Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a. State 10h County 10d. Inside City Limits 28a-f show traumatic avant, It's Mudical Examiner must be notified at 1 ☐ Yes 2 PNo Director Maryland St. Mary's Mechanics ville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö or Items 23a 39725 Hiawatha Circle 20659 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes. 2 □ No 1936-14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours atter of Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ■ No Specify: Specify: White If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lt. Commander U.S. Navy Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John B. Anderson Elizabeth C. Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 le any injury or other trai once. Patricia Ruth Anderson / Wife 39725 Hiawatha Circle, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 9-2-2005 Cheltenham, Maryland 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A 21. Sig Edward N. Brinsfield, M00052 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Malignant Effusion (Massive) P164821 Days /Medical Due to (or as a consequence of): Examiner Preymonia 1) 975 SEVEDZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Consestive heart failysz burial-transit 12945 that initiated events resulting in death) Last Due to (or as a c equence of): attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification; Division 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} To the Hospital within 24 hours a To the Funaral E 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15nato MD 120061719 8-30-2001 42 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAH ASSOC HOLLYWOOD MD DHANANJAY BHAVSAR 31. Date filed (Month, Danier 3 1 2005 32. Regis ar's Signature State a & feel Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10a-f.16a-b.19a-b. per Inf. G847 9/19/05 TT State of Maryland / Department of Health and Mental Hygiene 0.05

Reg. No. 2005 1 - For State Registrar 29318 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Shelton P. 20, 2005 Applegate August 1:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Nov. 24, 1928 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10X M 2 □ F Yrs. Director 224-32-8154 76 Virginia Usual Residence of Decedent with the Maryland 10a. State MA 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Exercises must be notified at Plymouth Plymouth 1**X**XYes 2X1N0 Funeral Directo MD Fréderick Fréderick 10e Street and Number 36 ½ Standish Avenue 49 Vienna Court 10g. Citizen of What Country? 10f. Zip Code 02360 21702 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces? ↑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Voivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Jife. DO NOTUSE ratified) Paleontologist 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) University Education Professor should be fit the and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ruit. Pages 1 and 2 should be partment of Health and Menta or rant: If item 27 is marked injury or other traumatic as John Morgan Applegate Rosalie Pleasants 19a. Informant's Name/Relationship (Type, Print)
Partner Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio 36 & Standish Avenue Plymouth, MA 02360 Vienna Court, Frederick, MD 21702 Evelyn Rattray Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State perrit. Page Depirtment of Important: If any Injury or once ¹ 4 □ Donation 5 □ Other (Specify) Hollywood Cemetery 8/24/2005 Richmond, VA 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License 1621 Opossumcown Fike Freder ist only one of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one of the death. 1621 Opossumtown Pike Frederick, Maryland 21702 Part1. En 24th discharge hock, or heart failure. Approximate Interval Between Onset and Death the disease Immediate Cause (Final Physician CEREBRO VASCULAR ACCIDENT 10 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC CARDIO-UNSCULAL سرمان لهركمادله (Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical use as the IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Cher (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? GRANULOMATUSIS 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to comptetion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hostice Certification: To 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Intury death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend after death Director: the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) MEDICO9-DIRECTOR 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D10587 AUGUST 20, 2005 HOSPICE OF FREDERICK COURTS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HD. LEDICAL DIRECTOR 516 TRAIL AVE. FREDERICA HD MITH gistrar's Signature 31. Date filed (Month, Day, Year) 32. 5 State AUG 2 6 2005 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Elizabeth S. Arnett

		ļ	1 - For State of Maryland State of Maryland		nent of Health ar		2005	29319
	Dhooisi		Decedent's Name (First, Middle, Last)	Cortina	bato of Beatiff	2. Date of Dea	ith Day Year	3. Time of Death
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be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examinat must be notified at once.	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 11 Yes, Give 1 □ Yes 7 ☒ Widowed 4 □ Divorced 1 □ Yes 7 ☒ Widowed 1 □ Divorced		res 2 No Specify:	Puerto Rican, etc.)	Black, Whit Specify: Wh	· ·
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	8 52	6	Part II. Other significant conditions of	ontributing to death	but not resulting i	in the underlying c	ause giver	n in Part I.	23e		use contribute to th	14
ord	w requir been si should	ed							_	1 ☐ Yes 2	□No 3□Prob	ably 4 Ounknown
of Vital Records,	hes b	Completed							24a	. Was an autopsy performed?	24b. Were autoprior to condeath?	psy findings available apletion of cause of
ai							<u>-</u>			Yes 28 No		2□ No
₹		o Be	25. Was case referred to medical examiner? 1 27 Yes 2 □ No	Hospital: 1 ☐ Inpati	ient 2 ☐ ER/O	utpatient 3 DC			of Death (Check		6 □Other (Specify	4
o	g Physer this erel di	n; To	27. Manner of Death	28a. Date of Inj	ury 28b.	Time of 2	8c. Injury	at		cribe how inju		9
Division	nding eth. r: Afte	Certification;	1, Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay rear)	Injury M	Work? 1 □ Y	r es 2⊡No	0			
i≥	r Atta	을	3 Suicide 6 Could not be determined	259. Place of in	ijury - At home, fa	arm, street, factory	, office		28f. Loca City	ation (Street and or Town, State	nd Number or Rura	l Route Number,
D	italo re aft											
	To the Hospital or Attending Physically the Within 24 hours after death. To the Funsel Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and makiner s	of examination ar	e, death occurred nd/or investigation,	at the time , in my opi	e, date and nion, death	place, and due occurred at the	to the cause(s) time, date and) and manner as st d place, and due to	ated. the cause(s)
	To the within To the complex	Ž	29b. Signature and title of certifier	1)		290	. License	number		29d. Da	te signed (Month, I	Day, Year)
	73		19 2 De	cher	MOM			045	8	AV	9 20,	2005
	7		30. Name and address of person who	completed cause of	death (Item 23a)	(Type, Print) & Silve	101	med	dicarl	Porks	10 r	
, F	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	A. No		- 1 1 /				***
No.	Registr	ar	AUG 24 21	005 8000	cs 15.	GOBALL						

			1 - For Stata Registrar	-		Depa		lealth a	nd Mental Hyg		000	29321
			Decedent's Name (First, Middle, Last					Doain	2. Date of Dea	ith		3. Time of Death
	Physici /Medi		clarence	e 1	Lates				August	22	2005	6:45 a ^M
8	Examir		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, Town, o	r Location of	Death	4c. Co	unty of Death	
			Montgomery Genera				Olney	If I ladar 0	A Head I a man a second		ntgomer	
	Funeral Director		5. Social Security Number 438-56-0624 Usual Residence of Decedent	ex 7.7 K M 2□F	Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 2	Min. 8. Date of Birtl (Month, Day June 10	, Year) 1940	9. Birthpl Coun Miss	ace (State or Foreign try) issippi
	yland pow		10a. State 10b. County		10c. City, To	own or Lo	ecation				10	0d. Inside City Limits
	e-fst	ctor	DC		Washi	ngto	n					1X Yes 2 ☐ No
	or 28	Oire	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
	s 23a	rai	1871 Newton Stree			1	2001			USA		
36	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28e-f show event, the Modical Evertiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force: 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	s?] No	İ	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		n? (Specify Yes or No- Puerto Rican, etc.)		Race - America Black, White, e ecify:	etc.
9	2 hou atura	ted	15. Decedent's Ed	lucation		Sa. Dece	dent's Usual Occup	ation		16b. Kind	Bla of Business/Ind	
215	thin 7.	Completed	(Specify only highest gra	de completed) College (1-4o	r 5+)	(Give life.	kind of work done DO NOT use retire	during most (d)	of working			
21	filed with Hygiene. Ither than	Con	10th			Ope1	ator Eng			Priva		
Maryland 21215-0036	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	Be	17. Father's Name (First, Middle, Last)						s Name (First, Middle, Tobah	Maiden Sui	mame)	
Ž	2 should and Men is marke eumatic	1º	Curtis Bates 19a. Informant's Name/Relationship (7)	Type Print)	1	9b Mailii	na Address (Street		or Rural Route Numbe	r City or To	own State Zin	Codel
	2 8 8 8		Eyvonne Bates/ Wi						NW Washing	-		
re,			20a. Method of Disposition		20b. Place		sition (Name of matory or other place		Date		ion - City or To	
imo	nit. Pages artment ot l ortent: if its injury or o		1 Surial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			Line	coln Ceme	teryAu	g.27,2005			
Baltimore,	permit. Page Department of Importent: if any injury or		21. Signature of Funeral Service Licen	Lenk					Johnson and NW Washing			
			23a. Part1. Enter the disease or comp shock, or heart failure. List only	cations that caus	ed the death. D			-				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ack							ST. 5	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequenc	e of):	70.70	Pi	Remice all a	Li de	USE	J. J.
ŀ	LAGITITICI	<u></u>	Sequentially list conditions,	b. Due to /or s	s a consequenc							
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	DO 10 101 2	s a consequent	e or).						
Ć,	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or a	s a consequenc	ce of):						
760,	a × a	cai		d								
68	rtitica ng phy as th		IF FCIALC.			OTT I						
.O. Box	The law requires that the death certiticat te has been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy Other (specify)	/		23d.	Date of deliver Month	ry Day Year
Δ.	s that ned by deta	by Pr	Part II. Other significant conditions of	ontributing to death	but not resulting	g in the u	nderlying cause grv	en in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
rds	quires en sign	ed b	detiin	117					1	9s 2 N	o 3□Proba	ably 4 Unknown
Records,	e law requ has been je 2 shoul	piet	Downie	5.					24a. Was a		4b. Were autop	sy findings available
Ä		Completed	Musica	Co 15-6	na	0	disci	213	pertor		death?	2 No
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	li	,			26. Place o	of Death (Check only or	18)		
of	Physi this o	2	1 Yes 2 No	Hospital: 1 Umpa		-		4 🗀 I4012	sing Home 5 Resid)
	ing Atter	Certification;	27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, E	ay Year)	Injury	Wor	yat k? Yes 2.∐No	28d. Describe h	ow injury oc	ccurred	
Division	or Attend atter death Director:	fical	3 ☐ Suicide 6 ☐ Could not be		njury - At home,	farm, str	eet, factory, office	100 2210	28f. Location (S	treet and N	umber or Rural	Route Number.
Div	Dir	erti	4 Homicide	building,	etc. (Specify)		,,,		City or Town	n, State)		
	To the Hospital or Attendi within 24 hours atter death To the Funeral Director: A completely filled in by the fi	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manner:	of examination	lge, deatl and/or in	n occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to the coccurred at the time, d	ause(s) and ate and pla	d manner as sta ce, and due to	ated. the cause(s)
)	To the within To the Comple	M	29b. Signature and title of certifier	evzi	, U-1	1)	29c. Licens	00/6	550	08	gned (Month, E	05
K	(5)		30. Name and address of person who defects the second seco	completed cause of	death (Item 23:	a) (Type,	Print) 99	01 M	reducil Ct	RPA	L. Rack	tulle ud.
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 4 2005	22. Regis	trar's Signature	dose	B					

OK per Vernita

			For State Registrar	State of Maryland		artment of H		d Mental Hy	giene C	005	29322
			Decedent's Name (First, Middle,	Last)				2. Date of De		Year	3. Time of Death
ł	Physici /Medic		Isabelle I	Brown					7/200		11:10a ^M
	Examin		4a. Facility Name (If not institution,			4b. City, Town, or				nty of Death	
			Holy Cross Ho		land blade (s.)	Silver If Under 1 Year				tgome	
ľ	Funeral Director		5. Social Security Number 577-26-8917	. Sex 7. Age (In yrs. II 1 M 桑口F 81	Yrs.	Months Days		Ain. (Month, D	rtn ay, Ye <i>ar)</i> 5 / 1 9 2 3	Coun	place (State or Foreign htry) ington, DC
	το		Usual Residence of Decedent	110.50					11123		
	arylar show	_	10a. State 10b. County		, Town or Lo					1	0d. Inside City Limits 1
	Ba-f	ecto	DC	Was	hingt				10g. Citizen o		
	a or 2	ä	10e. Street and Number 1000 Crittden	Ctroot NE		10f. Zip Code 2 0 0	1 7		U.S		itry ?
	eath	erai	11. Marital Status	12. Was Decedent Ever in U.	S. 13.			? (Specify Yes or N		lace - Americ	an Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show many injury or other traumatic event, the Medical Exerting must be notified at Once.	/ Funeral Director	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	In, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		Slack, White,	
8	urel',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						cify: Bla	
7	n 72 "nat	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b. Kind of	Business/Inc	Justry
12	withii ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	C1e		,		Pri	vate	
2	Hyg other ent,	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's	Name (First, Middle			
ylan	Mental Mental arked atic ev	To B	Benjamin Bre	at	,		Anni				
Maryland 21215-0036	d 2 shoth and the and the strain traum		19a. Informant's Name/Relationship Hazel M.S.And					<i>r Rural Route Numb</i> Lane Bow			
Baltimore,	os 1 an of Heal item 2 other		20a. Method of Disposition		_ lace of Dispo emetery, crei	osition (Name of matory or other place	ea)	Date	20c. Location	n - City or To	own, State
Ĕ	Page nent ant: If ary o		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify) Har	mony	Mem. Pa	rk 08	/24/2005	Land	over,	MD
alt	permit. Departr Imports any inj		21. Signature of Funeral Service Lie	De la companya de la	22	2. Name and Addres	ss of Facility	Taylor's	Fune	ral H	ome
_	201199		M. J. C.	Jaylo!	1.7	22 N.Ca	pitol	St.NW W	lashin	gtor.	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final					diac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Anoxic LI Due to (or as a consequ		alopathy	7				
П	Examiner			Gangrene		ec					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the development)	Due to (or as a consequ		-0					
	cuted nd ransit	Examiner	liial iiiilialeu everils	c							
oʻ	e exe ian ai urial-t	Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	icate be executed physician and s the burial-transit	dicai		d							
9	eath certific attending p for use as	/Med	IF FEMALE:	23c. If yes, outcome of pregna	IDCV.				204.5	Date of delice	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal	death 3	□Ectopic pregnancy □ Other (specify)				Date of delive Month	Day Year
o.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	1 □ Yes 22 No 9 □ Unknown	9□ Unknown	Jun 5 2						
<u> </u>	res that igned b be deta	by Pł	Part II. Other significant condition	s contributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ontribute to th	ne cause of death?
rds	quire; an sig uld bo	ed b						_ 10	Yes 2□No	3 ☐ Prob	ably 4 Unknown
Records,	law requir as been si 2 should	Completed						24a. Was		b. Were auto	psy findings available moletion of cause of
	The lay	mo				-		perfi 1 ☐ Yes	ormed?	death?	
Vital		Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only			
	di is	To	1 Yes 2 D	25.27	ER/Outpatier	- Indiana	4 🗀 Nutsir	ng Home 5□Res	idence 6 🗆 C	ther (Specify	v)
n C	ding Ph. h. After th funeral		27. Manner of Death XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	k?	28d. Describe	how injury occ	urred	
Sio	Attending r death. sctor: Afte	cat	2 Accident investiga 3 Suicide 6 Could no	t he	omo form ou		Yes 2 □ No	29f Location	(Stroot and Nut	mbar or Rusa	il Route Number,
Division of		Certification;	4 ☐ Homicide determin	ed 28e. Place of Injury - At ho building, etc. (Specify	y)	reet, ractory, onice			wn, State)	nber or nara	r noute Namber,
	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	edical C	(Check only 2 Medical E:	Physician: To the best of my knowaminer: On the basis of examinat	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and p pinion, death o	lace, and due to the	cause(s) and i	manner as st e, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Med	29b. Signature and title of Certifier	and manner stated.		29c. Licensi	e number		29d. Date sign	ned (Month,	Day, Year)
Ĺ	F 3 F 8			T.M.T	>	p6257	1		08/23		
1	10		30. Name and address of person w	ho completed cause of death (Item	1 23a) (Type.					, 2000	
K	-(4)		Dr.Sarah Brom				S ± 1 ·	ver Snri	no M	D 200	10
	Sta	ate	31. Date filed (Month Day, Year) AUG 2 4 20	2. Registrar's Signa	ture	. # A		· · · · · · · · · · ·	- 14 5 14.	~ ~ ~ 7	± V
	Regist	rar	700 2 4 21	in place to	6,20						

State of Maryland / Department of Health and Mental Hygien 2005 29323 Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** August 21, 2005 Robert Edward Belt III12:30 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woodside Center/Genesis Health Care Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) April 22,1969 Washington, D. C 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Days 1**X** M 2□ F 36 Yrs. Director 217-92-9411 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23e or 28e-f show the Medical Examinar must be notified at 1 XYes 2 □ No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1401 Tuckerman Street, N. W.; Apt.A-1 20011 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after dal Hygiene.
other than "neturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** Specify: δ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bail Bond Agent Bail Bond Express 12th grade permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic anona 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann Robert Edward BeltDeborah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert E. Belt II (Father) 1401 Tuckerman Street, N.W.; Apt. A-1; Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Aug. 29, 2005 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Park Landover, Maryland 21. Signature of Funeral Service Floorises 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acquired Immunodeficiency Syndrome years /Medical **Examiner** Human Immunodeficiency Virus Positive years Sequentially list conditions, if any, leading to an inediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): physician P.O. Box 68760 certificate be Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**X**i No 1 Yes Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After Hospital or Attending 1 X Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24, 2005 August D-32332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 Suresh K. Gupta, M.D.; 9801 Georgia Avenue; Suite 220; Silver Spring, Maryland 31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29324 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** Lawrence Andrew Borden August 2005 4:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3502 Easton Drive **Powie** Prince George's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 29, 1946 **Funeral** Days 1XM 2□F Months Hours 59 Director 085-36-2051 Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits rel', or Items 23e or 28a-f show Examirer aust be notified at 1 No 2 No MD Prince George's Bowie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 USA 3502 Easton Drive Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No Specify: Specify: White by 3 Widowed 4 Divorced "naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental If item 27 is marked Howard Robert Borden Alice Elliott 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda P. Borden / spouse 3502 Easton Drive Bowie, MD. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State njury or permit. Page Department of Important: If any injury or Metropolitan Crematory 08/24/2005 Alexandria, VA. 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 8 23a. Part1. Enter the disease, or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial infarction hour /Medical Due to (or as a consequence of): Examiner Diabetes 5 ears Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate ba executed Obesity lifetime Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months?
1 Yes 2 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) the n signed by #. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has al director, page 2 2 1 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Dobin, M.D. 4175 N. Hanson Ct. #203A Bowie, MD. 20716 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

Amended Items 4b, 4c, & 29c per Physician 08/24/2005 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005 29325 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 8 **Physician** : 17 P.M JERRY BROOKMAN C. 22 2005 /Medical 4b. City, Town, or Location Battimore 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner W.S.A. BACT: NAS NARYEANS

If Under 1 Year | If Under 24 Hrs. | 8. Date of B UNIVERSITY OF MARYLAND MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1 € M 2 □ F Months Days Hours Director April 4 1950 VA 216-58-9450 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County itam 27 is markad other than "natural", or frams 23a or 28a-f show other traumatic event, it is Ned 5al Expedit rount by notified at 1 XYes 2 No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157 USA 101 East Green Street by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after tonn of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Itel 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Concrete Supply Elementary/Secondary (0-12) College (1-4or 5+) Front End Loader Corporation 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Brookman Joyce Mitchell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 101 East Green Street Westminster, MD Deborah Brookman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 8/23/2005 Hampstead, MD 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. -KX 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coagulopathy 2 days Physician /Medical Due to (or as consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 si autopsy 1 Tyes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

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completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P18929 8/22/2005 ID#:15806 WJ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, HD 21201 DESSISLAVA BONEVA, MD 32. Recitrar's Signature 31. Date filed (Month, Day, Year) State Gleen & Spark Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** AUGUST 22, 2005 19:43 MICHAEL WINSTON BUSH, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL tf Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** (Month, Day, Year) SEPIEMBER 9.1950 Months **X**□M 2□F MARYLAND Director 212-54-7446 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND PRINCE GEORGES TEMPLE HILLS 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20748 UNITED STATES 4000 BRINKLEY ROAD death 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 1970
If Yes, Give Year or Dates: 197 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1970filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 1973 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) CONSTRUCTION LABORER YEARS CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental I int: If itam 27 is markad of JEAN CECILIA MILLS BUSH ROBERT BENEDICT BUSH, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY BUSH / WIFE 4000 BRINKLEY ROAD, TEMPLE HILLS, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 5 permit, Page Department of Important: If any injury or once. ARLINGION NATIONAL CEMETERY SEPT.15,2005 ARLINGTON, VIRGINIA 21. Signiture of Funeral Dervice his ansee THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 INDIA C. THORNTON JOHNSON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NU Physician /Medical Due to (or as a consequence) wic Examiner OXIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit or Attanding Physicien: The law requires that the death certificate be executed IA BETUS Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Nonknown been si Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2X No certificate 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 2 After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28h Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident I Diractor: d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

30. Name and a press of

31. Date filed (Month

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			30. Name and address of person w	ho completed cause of	death (Item 23a	a) (Type,	Print)					•	y •		
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State of Maryland / Department of Health and Mental Hygien 200529328 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 29 Elmer Spencer BAILEY August 2005 1:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clearview Nursing Home Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 ☐ F Director Yrs 705-12-3936 89 Jan 10 1916 Maryland Usual Residence of Decedent 10a. State 10b Count 10c. City, Town or Location 28e-f ehow 10d. Inside City Limits or then "netural", or iteme 23a or 28e-f ehov The Medical Exemiter is not be retified at Director 1 ☐ Yes 2/☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Sunflower Drive death Funeral 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 K Yes 2 □ No If Yes, Give Year or Dates: 1934–37 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other then "netural", or ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2X No 3 ₩ Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 - 7Conductor Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Robert Alburtus Bailey Sarah Thresa Finck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an ent: If Item 27 is ury or other treur 16126 Shaffer Road, Sharpsburg, Md. 21782 Lana Pittenger - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) Department of Importent: If any injury or once. Rest Haven Cemetery | 9/1/05 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FibINJU **Physician** tulminary Chionic /Medical Examiner the avenary Vancular discare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Huten102 Due to (or s a consequence of) Box 68760, physicien by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 10 Ho certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 W Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending s after decreal Director: After 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)0062223 30/05. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Praveen Bolarum

31. Date filed (Month, Day, Year) AUG 31 2005

5H-6+1

Hagerstown, Maryland 21740

340 Mill Street

32. Agistrar's Signature

			For State Registrar	State o	of Maryland /	Depa Ce	artment o	of Healt of Dea	h and th	l Mental Hy	giene Reg. No.	200	5 29	329
	Physici	an	Decedent's Name (First, Middle James Myron	e, Last) Bruckwich						2. Date of De Month	ath Day	Yea	3. Time o	
	/Medic		4a. Facility Name (If not institution				4b. City, Tov	vn, or Locati	on of De	August		2005 County of De	11:45	5 рм
199-1	·	3	Suburban Hosp	ital				hesda				Montgo	mery	
	Funeral		5. Social Security Number	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Y Months D	ear If Un ays Hou	der 24 H rs Mi	n. (Month, Da	y, Year)		irthplace (State Country)	
	Director		388-32-9431 Usual Residence of Decedent		71					April 3	5, 19	34 W	sconsir	1
	uryiano show		10a. State 10b. County		10c. City, To	own or Lo	ocation						10d. Inside (_
	he Ma	Directo		gomery	Silv	er S	pring	4.			10- 011			s 2 ≅ No
	with t	iOir	10e. Street and Number 2425 Dexter Av	enije			10f. Zip Co	902			rog. Citiz	en of What our	Country ?	
	death	Funeral	11. Marital Status		edent Ever in U.S.	13.			Origin?	(Specify Yes or No erto Rican, etc.)	. 1		nerican Indian,	
36	or Ite	by Fu	1 Never Married 2 Mar	ried 1 ☐ Yes If Yes, Gi	2 🖪 No ive		1 ☐ Yes 2 🔀			ano moan, etc.)		Specify: Wh		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23a or 28a-f show aumatic event, the Modical Exertimer: Market Indifficulation.	ed b	3 ☐ Widowed 4 🛣 Divorced	Year or E		Sa. Dece	dent's Usual O	ccupation				wr nd of Busines		
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2	ygiene ygiene her tha			4		Own	ner	10.10		(F) . M. (4)			Busines	s
and	intal H ed otl	Be c	17. Father's Name (First, Middle, Frank Bruckwie							_{lame (First, Middle,} ie Imansk		Sumame)		
ary	should nd Me nmark umath	ဥ	19a. Informant's Name/Relations		1	9b. Mailii	ng Address (St			Rural Route Numb		Town, State	, Zip Code)	
Ž	and 2 salth a n 27 le	ľ	Michael P. Bru	ckwick/ So	1000	-spelling			ıe,	Silver Sp	ring	, MD 2	20902	
Baltimore,	ges 1 t of He if Item		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 🗀 Removal from	ceme	of Dispo	sition (Name of matory or other	of place)	A	Date ugust 29,	20c. Loc	cation - City o	or Town, State	
	rimen rimen	l 4	4 □ Donation 5 □ Other (5		Metro		an Cremat			2005			, Virgi	nia_
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Numeroother traumatic wones		De Alexandre	2-13 :	201	Fi 50	rancis 00 Univ	J. Co ersit	llin y Bl	s Funeral vd, W, Si	. Hom .lver	e Inc Sprin	ig, MD 2	20901
-8	\$ 8 g		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death. Deach line.								Approxima Interval Be	ite itween
, sillo	Physician		Immediate Cause (Final disease or condition	_a Aspi:	ration Pne	eumor	nia						Onset and	
	/Medical Examiner		resulting in death)		(or as a consequence	-								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. End-S	Stage Hepa	atit:	LS						leare	
	cuted nd ransit	Examiner	that initiated events		nic Renal		lure						Years	
8760,	ate be executed hysician and the burial-transit	al Ex	resulting in death) Last	Due to	(or as a consequence	ce of):								
687	ficate physis the	edicai		d.									1	
Вох	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy birth 2 Fetal dea	ath 3.Γ	JEctopic pregn	ancv			2	3d. Date of d		
G.	that the death cer ed by the attendin detached for use	/sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of death		Other (specif					Month	Day	Year
P.O.	res that thigned by		Part II. Other significant conditi	ons contributing to d	leath but not resulting	g in the u	nderlying caus	e given in P	art I.	23e. Did t	obacco us	se contribute	to the cause of	death?
rds	quires n sign uld be	ed by	Altered Mental	Status						10	Yes 2□]No 3★	Probably 4	Unknown
900	taw requir as been si 2 should	Completed								24a. Was		24b. Were	autopsy findings completion of	available
Ž	The cete his page	Com									rmed?	death′ 1 ☐ Ye	?	544 30 0
<u>S</u>	tician: Th certificete rector, pag	Be	25. Was case referred to medica examiner?	Hospital:						eath (Check only o				
ō	Attending Physician: or death. ector: After this certifice by the funeral director.	n: To	1 ☐ Yes 2 🙀 No 27. Manner of Death	28a. Date	of Injury 28b	o. Time o	nt 3□ DOA f 28c.	Injury at Work?	Nursing	Home 5 Resident			pecify)	
<u>0</u>	anding lath.	atio	1 Matural 5 ☐ Pendii 2 ☐ Accident investi	gation	nth, Day Year)	Injury		vvork? 1 ☐ Yes :	! □ No					
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	ertification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	e of Injury - At home, ling, etc. (Specify)	farm, sti	reet, factory, of	fice		28f. Location (. City or To		Number or i	Rural Route Nur	n <i>ber</i> ,
	spital ours a neral [O	29a. Certifier 1K Certifyii	ng Physician: To th	e best of my knowled	dge, deat	h occurred at ti	ne time, dat	and pla	ce, and due to the	cause(s)	and manner	as stated.	
	the Hospital nin 24 hours a the Funeral i	edicai	(Check only 2 Medical one)	Examiner: On the b	pasis of examination iner stated.	and/or in	vestigation, in	my opinion,	death oc	curred at the time,	date and	place, and d	ue to the cause	s)
	within To the	Σ	29b. Signature and title of certific					cense numb		1			nth, Day, Year)	
•	3			ue;		- \ /=		1960	7		0.0	13.0	5	
			30. Name and address of person Raman Tuli,		se of death (Item 23; 10 Darnest			#202,	Gai	thersburg	, MD	20878		
NS.	Sta		31. Date filed (Month, Day, Year,	-				····						
	Regist	ar	AUG 24	ZUUD SO	Registrar's Signature	Jan Jan								

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Bryciswicis, James 11:45PM

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 29330 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician EARLENE CHEEK Month Year 10:25 A 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Lanham Doctor's Comunity Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day August 22 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 1□M 2 .°1923 **Funeral** North Carolina 81 Director 243-56-6837 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County or 28a-f ehow the Nedical Examiner must be notified at Halifax 1ÀSYes 2 □ No North Carolina Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 27839 U.S.A. 120 Dobbs Street 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Black ŏ 1 Yes X No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 → Widowed 4 □ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chowan Area Dove Admin. Social Worker 12th grade (Retired) 17. Father's Name (First, Middle, Last)
Willie Williams 18. Mother's Name (First Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othing any injury or other traumatic event 20.8. Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Hunt Drive Jericho, New York 11753 Carol C. Francis (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Crestview Mem. Cemetery August 24, 2005 Roanoke Rapids, NC XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rollins Funeral Hime, Inc. 22. Name and Address of Facility 21. Signature 4339 Hunt Place, N.E. Washington, D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Showk Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the al Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. Injury at Work? in by the funeral 27. Manne of Death Date f Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deal To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Curtifying Physician: To the best of my knowledge, death occurred at the time, date and dade, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertified EFENSE HIGHWAY A WAPOLISM D 21401 EN 31. Date filed (Month, Day, Year) State 5 2005 Registrar

DHMH 17 Rev 1/2001

			For State of Maryland / Departi	ment of Health and Me <i>licate of Death</i>	ental Hygien Reg. N		29331
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b.	o. City, Town, or Location of Death		3 3005 tc. County of Death	13:15 PM
	Funeral Director	CI	Lenin Sula Legional Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs.	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Yea (9 - 2	y/iCOMIC 9. Birthpl Count	lace (State or Foreign try)
	e Maryland e-f show lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati Salisbur	on		10	0d. Inside City Limits 1 ∰Yes 2 ☐ No
	3s or 28	ai Dire	10e. Street and Number	2 8 0	10g. C	Citizen of What Coun	try?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. Item 27 ie marked other then "naturel", or Items 23a or 28e-f show other treumetic event, the Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 M Married 1 Never 2 ☐ No 4 ☐ 0 ~ (Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto R Yes 25 No Specify:	cify Yes or No- lican, etc.)	14. Race - America Black, White, e Specify:	an Indian, etc.
Maryland 21215-0036	thin 72 hou e. en "nature Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kinclife. DO]	's Usual Occupation of work done during most of workin NOT use retired)	g 16b.	Kind of Business/Ind	lustry
1d 21	e filed within at Hygiene. other then 'vent, the We	Be Con	12-th 17. Father's Name (First, Middle, Last)	Layer 18. Mother's Name	(First, Middle, Maide	INStrust en Sumame)	ion Co.
rylar	2 should be and Mental le marked creumetic eve	To B	Rohert Checks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or Rural	UKNOU	Or Town State Zin	Code)
	as 1 and 2 s of Health an f Item 27 ie i r other treui		Ella Cheeks (Wife) 905 G	ateway Stree-	+ Salish	wy mol	21801
Baltimore,	Page ment o ent: ff ury or		20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Sign thre of Funeral Service Licensee	(Name of pry or other place) (Engtany 8-27) ame and Address of acility Research	-05 H	ebrou /	nd, rul Home
B B	permit. Departi Importi eny inj		Miscella Ennde P.O	, Box331 Pocon		-4, md. 2	1281
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Lucy Arvel	respiratory arrest,		Approximate Interval Between Onset and Death
1 (***)	Examiner	L	Due to (or as a consequence of): Sequentially list conditions, b.	otansim	2		Herry
7486 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, backing to him solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Cause to (or as a consequence of) c. Due to (or as a consequence of): d.	dienjoplu	1		
13-16.	that the death certifued by the attending I	Physician/Me		topic pregnancy her (specify)		23d. Date of delive Month	ry Day Year
∠ ds, P	signed b	by	Part II. Other significant conditions contributing to death but not resulting in the under	tying cause given in Part I.		o use contribute to th	e cause of death?
ecks	The law requirence of the second of the seco	Completed	Dementia		24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
Chy	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death Other: 4 Description Hom			
eph not	di S	on: To	1 Yes 2 6 1 I I Inpatient 2 S Outpatient 3 7. Mapper of Death 28a. Date of Injury (Month, Day Year) 1 Injury 1 Injury	3 DOA 4 Nuising Hom	e 5 Residence Bd. Describe how in	6 ☐Other (Specify jury occurred)
Jose, Division	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:		M 1 ☐ Yes 2 ☐ No factory, office	Bf. Location (Street a City or Town, Sta	and Number or Rural ate)	l Route Number,
	e Hospite 24 hours e Funerel etely fillec	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death oc and manner stated.	curred at the time, date and place, ar igation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month, L	Qav. Year)
C.H	(ot)		30. Name and address of person to completed cause of death (Item 23a) (Type, Printle Constitution), Constitution (3 WO S. Division)	st solizbul	peo.	21804	
,,,	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 5 2005 32. Jegistrar's Signature	W.			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				State of Marylar		nent of Health and	d Mental H	and the same		
					Certific	cate of Death		Reg. No 20	05	29332
	Physician	1 ,	1. Decedent's Name (First, Middle, Less	ivel (rowd	ler	2. Dete of D	Day	Year 05	3. Time of Death
	/Medica Examine		4a Fecility Neme (If not institution, give	street end number)	1 10	4b. City, Town,	or Location of Dee	th 4c. County	of Death	
			Prince Georg	es Hospi	tal Cer	HR Chey		(P) (هـر	
	Funeral Director			x 7. Age (lh yrs. □M 2)XIF	Yrs. If U	Inder 1 Year If Under 24 Hours Market School Control of the Contro	in. (Month, D	irth Pay, Year)	9. Birthp Coun	ace (State or Foreign
	pue *	- 1-	Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location				10	Od. Inside City Limits
	the Meryler 28e-f show	5	mr Prince	12 sames 2	ladios	Heights			İ	1 1 Yes 2 No
	or 28e	3	10e. Street end Number	ourges 4	10	f. Zip Code		10g. Citizen of W	/hat Coun	try?
	th wit	2	910 574	Place		20743		45	A	
	offer death with the Me r items 23a or 28e-f s eliner must be notified		11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was D If Yes,	Decedent of Hispenic Origin? specify Cuben, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	o- 14. Race Blac	- Americ	
20			1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: TN	101	es 22 No Specify:		Specify.	RI	ak
5-0020	led within 72 hours e lygiene. Per than "naturel", o et, the Medical Exer- Commissed by	3	15. Decedent's Edu	ication	16a Decedent's	Usual Occupation		16b. Kind of Bu	siness/Inc	ustry
215	c 3		(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give kind o	of work done during most of v OT use retired)	vorking			
2121	filed withir Hygiene. ther than int, the	5 -	Infani	INfant	IN	iani		INFO	Ins	
Maryland	should be filed and Mentel Hygi marked other immit event, I		17. Father's Name (First, Middle, Last))		18. Mother's N	lame (First, Middl	e, Maiden Surnam	θ)	
3	d Men d Men marke maric	2 -		DENN	10h Mailing Ada	dress (Street and Number or	LIA Bural Bauta Alum	2 MAN I	/+/4 N/ Stata Zia	Code 2 ETIES
Ma	2 g m 5	i.	19a. Informant's Name/Relationship (T)	other Mile		574h Place		al Ha	oht	S m/ 13
ē,	tem 2	F	20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of	Date	20c. Location -	City or To	wn, State
Ë	2 2 2 2		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☑ Other (Specify)	removal from State	P.G.H.C		08/23/200	CHEVE	RLY	MD
Baltimore,	# 분 원공 .	1	21. Signature of Funeral Service Licens	40 DUSD TH		ne and Address of Facility		Cribite		, , , ,
8	Depermination of the series of		Reano M. C.	Uneb	300	HOSPITAL I	DRIVE, C	HEVERI	Y. N	10 20785
		1	23a. Part1. Enter the diseese, or composhock, or heart failure. List only of	lications that caused the dea						Approximate Interval Between
	Physician						1			Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	e. / 2v	or as a consequence	another !	W			
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o	Physic rthis c and din	٠ ا	1 ☐ Yes 2 ☑ No 27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of	DOA 4 Nursing 28c. Injury at Work?		idence 6 Othe	. , ,)
ion	Attending ir death. actor: After by the fune		1 Neturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey Year)	Injury M					
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	To the Hospital or Attending Physician: within 24 hours efter death. To the Funerel Director: After this certifica completely filled in by the funeral director, Medical Certification: To Be (sician: To the best of my kno ner: On the basis of examine end manner steted.						
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			Brownst	1/2		D47958			8/2	2/05
			30. Name and eddress of person who co	ompleted cause of death (Item	m 23e) (Type, Print)	-				Į.
	y.		Raymond Cox 31. Date filed (Month, Day) [10]	3001 Hospita	l Dr. Chev	verly, Md. 20	785			
	State Registrar		OI. Date filed (Month, Day) Bath	8 2095 Registrar's Sign	and the for	man				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2005 29333 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 10:22 P^M <u>Aaron Douglas Dowell</u> 2005 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F Months Days Yrs. Director 578-42-4380 24, 1935 South Carolina Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir then "naturel", or Items 23e or 28e-f show the Medical Evaniner must be notified at 1 Yes 2 □ No Completed by Funeral Director DC Washington the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1007A Eye St., N.E. 20002 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
shert of Health and Mental Hygiene.
shert if the 27 is marked other then "naturel", or Items 23, any or other treumatic event, it as Medical Eventinal must <u>United</u> States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) U.S. Postal Service Elementary/Secondary (0-12) College (1-4or 5+) Government Clerk Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be P Eddie Dowell Cordell Toney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Hatcher Lyon/Sister 5900 -3rd St., N.E. Wash., DC 20011-1608 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or * 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 8/30/2005 Suitland, MD 21. Signature of Furreral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last mon Due to (or as a consequence of): Physician/Medical Examiner burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed ar anoma Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 1 Yes 2 3 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 (Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Vatural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) filled in 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARIM, 7610 CARROLL AVE, STE340, 31. Date filed (Month, Day, Year) State AUG 2 4 2005 Registrar

			For State Registrar	State of	Maryland		artment of F		nd Mental	Hygie:	ne No.2005	29334
	Physici /Medio		1. Decedent's Name (First, Middle, Lass Leona F. Deitz						Augu	of Death h I St 1	Day Yeer 8, 2005	3. Time of Death 8:15 A. M
	Examir	er	4a. Facility Name (If not institution, give 14401 Traville	Garden (Circle		4b. City, Town, o	ville			4c. County of Dea	ery
ŀ,	Funeral Director		5. Social Security Number 6. Security Number 170–20–9935 Usual Residence of Decedent	x 2□ F 7.	Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mont	of Birth th, Day, Ye 8, 1	9. Bit 924 Pen	thplace (State or Foreign ountry) nsylvania
	Maryland a-f show	tor	10a. State 10b. County Maryland Montgome	rv	10c. City, T		ocation					10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28a	Funeral Directo	10e. Street and Number 14401 Traville Gar				10f. Zip Code 8 20850				Citizen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: it Item 27 is marked other then "naturel" or Items 23a or 28a-f show may njury or other treumatic event, It a Medical Ever'ill sermant be inclified at once.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? [X No	1	Was Decedent of H If Yes, specify Cub 1☐ Yes 2☐ No		in? (Specify Yes Puerto Rican, etc	or No-	14. Race - Am Black, Whi Specify: W	te, etc.
21215-0036	vithin 72 hounde.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4	or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most d)	of working		. Kind of Business	·
nd 21	al Hygier d other th	Be Col	17. Father's Name (First, Middle, Last)	2 Years	3	0:	ffice	18. Mother	's Name (First, M		Synagogu den Sumame)	e
Maryland	should b	Tol	Joseph J. Fisch		1	19b. Mailir	ng Address (Street		rah Gros		ty or Town, State,	Zip Code 2 0850
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Baltimore,	Pages nent of h		20a. Method of Disposition 1 Burial 2 Cremation 3 2 4 Donation 5 Other (Specify,	Removal from St	ate ceme	etery, crei	cremator		/19/2005		Location - City or	ch, Virginia
Balti	permit. Departn Importe any inju		21. Signature of Funeral Service Licens	Dtote	temp	, 22 E	Name and Addre	ss of Facility	neral Di	recti	on, Inc.	land 20852
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aLymp	chona as a consequen	Oo not ent	er the mode of dyir	ng, such as c	ardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death
8760,	FEE	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last	c	as a consequen							
P.O. Box 68	The law requires that the death certiticate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 Fetal dent at time of death	ath 3	Ectopic pregnancy	1			23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	intributing to deal	th but not resultin	g in the u	nderlying cause giv	en in Part I.		Did tobacc	_	o the cause of death?
I Reco		Completed								Was an autopsy performed (es 2011	? prior to death?	utopsy findings available completion of cause of 2 No
Division of Vital Records,	Attending Physicien: The death. ector: Atter this certificate by the tuneral director, pag	atlon: To Be	27. Manner of Death 1 Natural 5 Pending investigation			Outpatier b. Time of	f 28c. Injur Wor	er: 4 🗍 Nurs	28d. Desc	Residence	6 Vether (Spe	ocify)Hospice
Divis	ital or Attenirs atter deatirel Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building	, etc. (Specify)		eet, factory, office		City o	or Town, St	ate)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely tilled in by	Medical	29a. Certifier (Check only one) 2 ☐ Medical Exam 29b. Signature and title of certifier	rsician: To the be iner: On the basi and manner	is of examination	dge, deatl and/or in	h occurred at the tir vestigation, in my o	pinion, death	place, and due to a occurred at the t	time, date a	e(s) and manner as and place, and due Date signed (Mont	e to the cause(s)
)	6		· MAMIC	- M	t D.	n) (Tre-	D53				ugust 19	
			John M. Wallmark	, M. D.	9707 Med	lical	Center 1	Dr, Su	ite 300,	Rock	ville, M	id. 20850
	Sta Registr	_	AUG 2 4 20	105 32 neg	gistrar's Signature	190	ale					

			1 - For State Registrar	State of Ma	aryland / Der <i>Ce</i>	ertificate of	lealth and N Death	Mental Hygi	ene 2 0 0 5	29335
	Physici /Medic		1. Decedent's Name (First, Middle, L FREDERICK	0.	FADOJU	TIMI		2. Date of Death Month August	Day Year	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, g 32/5 Toledo 5. Social Security Number 6. 579-78-8248	flace 7	F/O/ e (In yrs. last birthda) Yrs.	Hyatts	r Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Septembe	4c. County of Death	place (State or Foreign intry) ERIA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Introprent: If item 27 is marked other than "natural; or Itams 23a or 28e-f show eny injury or other traumatic event, the Macilcal Event are must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Prince 10e. Street and Number 3215 Toledo Pla 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of Specify only highest of Specific only highest only highest of Specific only highest only h	12. Was Decedent if Armed Forces? 1	19b. Mai 781 20b. Place of Discometery, or Church	10f. Zip Code 20784 Was Decedent of Fif Yes, specify Cubr 1 Yes 2 No edent's Usual Occupe kind of work done DO NOT use retired Countant ling Address (Street 0 Barry P cosition (Name of ematory or other place Cemetery 22. Name and Addre	dispanic Origin? (Span, Mexican, Puerto Specify: sation during most of work of the state of the	pecify Yes or No- Prican, etc.) aing e (First, Middle, Ma Adegbulug Fal Route Number, C rict Heig Date 20 6/05 B. Jenk:	g. Citizen of What Cou U.S.A. 14. Race - Ameri Black, White Specify: Sb. Kind of Business/Ir Private aiden Surmame)	p Code) and 20747 fown, State Home
of Vital Records, P.O. Box 68760,	ding Physicien: The law requires that the death certificate be executed XB Lander this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	ion; To Be Completed by Physiclan/Medical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cadse (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	y one cause on each lir a. Due to (or as: b. Due to (or as: c. Due to (or as: d. 23c. If yes, outcome 1	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 time of death 5 at not resulting in the	Ectopic pregnancy Other (specify) underlying cause giv	en in Part I. 26. Place of Deat er: 4 \(\text{Nursing Ho} \) \(\text{var} \)	23e. Did toba 1 Yes 24a. Was an autopsy performs 1 Yes 25	23d. Date of delive Month 2 No 3 Prolumber 1 Prior to condeath? 1 Yes 24b. Were authorized to the condeath? 1 Yes	ery Day Year the cause of death? bably 4 Henknown posy findings available impletion of cause of 2 No
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	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or L	ocation of Death		4c. County of Deat	
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	Funeral Director		218-11-9149	Sex 7. Age 1 ☐ M 2 ■ F	(In yrs. last birthday) 19 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 26,	9. Birt Co 1986 Mary	hplace (State or Foreign untry) 11and
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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	deeti	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,			14. Race - Ame Black, White	rican Indian,
21215-0036	d within 72 hours after deeth with the Maryland jiene ir than "natural", or items 23a or 28s-f show the Madical Expression out be notified at	þ	1 to Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ■ No			Specify: Whi	
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ano	a la la	To Be	John Howard Tha		,		Virgin		,	
Maryland	d 2 should I th and Men 7 is marke traumatic	ř	19a. Informant's Name/Relationship			ing Address (Street an			ity or Town, State, 2	Zip Code)
	nd 2 lith a 27 is r tra		John H. Francis	/ Father	2535	O Pinto Dr	ive, Hol	lywood, M	Maryland 2	20636
J.e.	07		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3	Damaual from State	20b. Place of Disponentery, cre	osition (Name of ematory or other place)) D	ate 20	c. Location - City or	Town, State
Ĕ	Pages ment of the ent: if its ury or of		4 ☐ Donation 5 ☐ Other (Spec	i(y)		ge's Episc		-2005 Va	lley Lee,	Maryland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Local	NA MOU	252 2		wood Road	i, Leonar	dtown, MI	Home, P.A. 0 20650-0279
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do not en	nter the mode of dying,	such as cardiac of	r respiratory arrest		Approximate Interval Between
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		Physician: To the best of miner: On the basis of and manner sta	examination and/or in					
	To the	₩.	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Mont	h, Day, Year)
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1	300		30. Name and address of person wh	completed cause of d		, Print)		OTMODE ::	IATISZT ABTD	21.201
_	'A'		Tasha Z G	reenbera	M.D. 11	I PENN STR	EET, BALT	LIMORE, M	IARYLAND,	21201
	Sta Regist	ate rar	31. Date filed (Month) By, year	005 33 Aegist	ar's Signature	and .				

Robert L. Foreman 05-05852 MU

Maryland 21215-0036

Baltimore,

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of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10e&19b&

1- State Unpend Item 23a, 27, 28a-f per me 6847 9-20-05 tas
Reg. No. Reg. No. 005 29337 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician August 30 2005 1933 Robert Lake Foreman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1**₽**M 2□F Months Days Director 53 <u> 213-68-1243</u> Aug 4, 1952 Maryland Usual Residence of Deceden Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f ahow Completed by Funeral Director 1 ☐ Yes 2 X No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2306 Sandel Lane 21157 USA Hygiene. other than *natural; or Items 'ant, the Madical Examiner ma 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 20 Married 1 ☐ Yes 2X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Production Team Member COLA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be f Mental I Marie E. Walker 10 Edward A. Foreman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sandel 19a. Informant's Name/Relationship (Type, Print) f Health 2306 Sadel Lane Westminster, MD 21157 other Susan J. Foreman 20a. Method of Disposition Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ₩ Burial 2 Cremation 3 Removal from State ŏ permit. Page Depertment of Important: If any Injury or once. 9/3/2005 Eldersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Pk. 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee 412 Washington Rd. Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Asphyxia complicating ruptured berry aneurysm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit Due to (or as a consequence of): physicien ician/Medicai the d as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ò Day Year 4☐Pregnant at time of death 5 Other (specify) tached Physi 9 Unknown 9 Unknown be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 □ No 25. Was case referred to medical Be 26. Pface of Death (Check only one) examiner' Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 2 XER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 6:44^y found p or Attanding Natural 5 Pending efter death. 2X Accident found 1 ☐ Yes 2 ☐ No investigation accidental asphyxia 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2306 Sandler Lane Westminster, Maryland filled in by 4 - Homicide To the Hospital of within 24 hours of To the Funerel Discompletely filled in home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NSL 24 OCME August, 31, 2005 0 11 30. Name and address of person who completed cause of de th (ftem 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Greenheig asha 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar



DHMH 17 Rev 1/200

Registrar **DHMH 16 Rev 6/95**

State

			1 - For State of Maryland / Departm	nent of Health and Ment cate of Death	tal Hygier	2005	29339
			Decedent's Name (First, Middle, Last)	2. D	ate of Death		3. Time of Death
н	Physici: /Medic		MARY GROOMES FOSTER			Day Year 22 2005	6:40 A M
	Examin		0100120	City, Town, or Location of Death	7444	4c. County of Death	0:40 A
				Gaithersburg		Montgomer	V
	Funeral		Mor	nths Days Hours Min. (A	ate of Birth Month, Day, Yea	ar) 9. Birthpi Coun	ace (State or Foreign
	Director		551 36 8596 91 Yrs. Usual Residence of Decedent	Ju	ine 20]	1914 Mary	land
	vland ow		10a. State 10b. County 10c. City, Town or Location	1		11	0d. Inside City Limits
	Mar.	tor	Md. Montgomery Gaithersbu	urg			1 No 2 No
	th the	Director	10e. Street and Number 10e	Vi. Zip Code	10g. (Citizen of What Coun	try?
	23a		301 Russell Avenue	20877	J	Inited Sta	tes
	tems	Funerai	Armed Forces? If Yes,	Decedent of Hispanic Origin? (Specify) , specify Cuban, Mexican, Puerto Rican	Yes or No- n, etc.)	14. Race - America Black, White, 6	
36	s afte	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 M No If Yes, Give 1 □ Ye 3 □ Widowed 4 M2 Divorced Year or Dates:	es 2 No Specify:		Specify: Whi	te
8	hour tural	ed t		Usual Occupation	16h	Kind of Business/Inc	
75	n "ne n "ne Wedik	Completed	(Specify only highest grade completed) (Give kind of life, DO NO	of work done during most of working OT use retired)	100.	. Tand or basinosame	lustry
212	d with	E O	70	retarv	Re	search Lal	ooratory
pu	al Hyg	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs			1
<u> a</u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked othar than "natural", or Items 23a or 28a-f ahow aumatic evant, the Macical Exarta activities a willied at	10	Walter Groomes	Margaret	Myer		
Maryland 21215-0036	2 she and Is m			dress (Street and Number or Rural Rou			Code)
	1 and 1 Health tem 27			N. High St., Olney		20832	0
Baltimore,	Pages nent of hant: If ite		1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State	y or other place)		Location - City or To	wn, State
Ē	nith Parish			Cemetery 8/25/05	C	lney, Md.	
Ba	permit. Pages. Department of H Important: If its any injury or of		muried of Barks Muri	ne and Address of Facility Lel H. Barber Fune	ral Hom	ne 2088	0 າ
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the	Box 5038, Layto:	nsville	, Md. 2000	Approximate
k			shock, or heart failure. List only one cause on each line.	1			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	indlomy opath	Y-		10303
	Examiner			,	J		
	n =	ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying				
	acute ind trans	Examiner	that initiated events c.				
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ē	Due to (or as a consequence of):				
87	physi the t	dicai	d			1	
9 ×	eath certific attending p for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
Вох	atten I for u	cian	in the past 12 months?	pic pregnancy er (specify)			Day Year
P.O.	that the de ed by the a detached i	nysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	,,			
	res that igned b be deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying	ring cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
5	w require been sig should b	ed b			1 🗌 Yes	2 No 3 Proba	ably 4 Unknown
Records,	aw re	Completed		2	24a. Was an autopsy	24b. Were autop	osy findings available
	sician: The law certificate has b irector, page 2 s	mo		1	performed	death?	
Viital	ysician: is certifica director, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (Che			
<u>></u>	Physic this ce al dire	2	1 ☐ Yes 2 € No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐		5 🗌 Residence	6 □Other (Specify)
Ē	iding Phy th. : After thii : funeral c		27. Manual of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	Describe how in	jury occurred	
<u>sio</u>	r Attandi er death. rector: A by the fu	cati	2 Accident investigation M				
Division of	I or Attano after deatl Director: I in by the	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ictory, office	city or Town, Sta	and Number or Rural ate)	Houte Number,
	To the Hospital or Attanding Physician: while 24 hours after death as a factor. To the Funeral Director. After this certifical completely filled in by the funeral director.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occu	urred at the time, date and place, and du	ue to the cause	(s) and manner as sta	ated
	e Ho 24 h e Fui letely	Medical	(Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred at t	the time, date a	and place, and due to	the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and the of certifier	29c. License number		Date signed (Month, E	Jay, Year)
)	12		> / Who I show it	0. 20148	H	ugust 22	2005
	100		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	511 0 44 0	-		
			Steven Dolinsky mo 9	III Russell Ave.	, Oath	xapond	Md
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 4 2005 32. Begistrar's Signature	W			
	riegisti	-1	The same of the sa				

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 017116 toomer 4 Ve If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Wonth, Day. Birthplace (State or Foreign 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 4 56 577-66-341 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b Agunty 28e-f show other freumatic event, the Medical Examiner must be notified at 1₽Yes 2 No Director Trince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 USA or Items 23g OWN DIVE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 700 Specify: ack 3 ☐ Widowed 4 ☐ Divorced "neturel". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry fited within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then any injury or other treumatic event. It a Me. Elementary/Secondary (0-12) College (1-4or 5+) ICEV Ammigration C 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be e oh a 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Type, Print) Sun 4307 Cinibar Md 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Lossion - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mem. tark Landover Aug. 26, 2600 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ralph Williams 1813 Petunae Me. Funeral Service Licensee 21. Signatur Service Funeral (3) SE Washington DC 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician STatic /Medical Due to (or as a consequence of): **Examiner** Venon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Examine certificate be executed burial-transi Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 40 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 1 🗌 Yes 2 2 No 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) 2 funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred After t Certification: To the Hospitel or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funerel 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0056063 5 eted cause of death (Item 23a) (Type, Print) 30. Name and address of person while Forest Glen Rd Silver Spring MD 1500 Kan wal Day, Year) 2. Registrar's Signature State AUG 2 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar 29341 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Charles Henry Glass, Sr. 2005 14:07 /Medical August 19. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Clinton
If Under 1 Year If Under 24 Hrs. Prince Georges Southern Maryland Hospital **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 1☐M 2☐F Days Months Min. 59 419-54-2499 Director Yrs. Oct. 15. 1945 Birmingham, Al. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ment of Health and Mental Hygiene.
mit: if tame 72 is marked other than "naturel", or items 23a or 28a-f show ant: if tame 72 is marked other than "nature" and it has Medical Expringer than 12 in williad at any or other traumatic event, the Medical Expringer than 12 in williad at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Direct Maryland Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3302 Strawberry Hill Dr. 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 € Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Rackman Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Lee Glass Daisey Mae Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany D. Simmons-Glass/Wife 3302Strawberry Hill Dr. Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. ` 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Aug. 29,2005 Cheltenham, Md. 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service Lios 0701085 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE performed' 2X No 1 ☐ Yes 2 ☐ No 1 Yes i or Attending Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 Inpatient 2 GER/Outpatient 3 DOA Diractor: After th 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 A Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JOBRU D40324 AUGUST 22, 2005 ddress of person who completed cause of death (Item 23a) (Type, Print) JODRIE, MID. 7503 SURRATTS ROAD, CLINTON, MARYLAND 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar AUG 2 4 2005

		•	For State Registrar		State of	Marylan		artment tificate			ind Me			2005	5 29	342
	Physici		1. Decedent's Name (Firs Mollie S. Gil	- Author	ist)							2. Date of Dea Month August 1	Day	Yeer	3. Time of 1:10am	Death M
3	/Medic Examin		4a. Facility Name (If not in		e street and num	ber)		4b. City,	Town, or	Location o		range i	7	County of Deat		-
	LAUITIN		Millenium Hea	i th and	Rehab Cent	er		Fore	estvi	lle			Pr	rince Geo	inges	
	Funeral		5. Social Security Number	6. 3	Sex 7	. Age (In yrs.		If Under Months	1 Year Days	If Under	Min.	B. Date of Birth (Month, Day	, Year)	9. Birt	hplace (State or puntry)	Foreign
	Director		209 12 0391		1□ M 2□ F	81	Yrs.					Tune 12,	1924	Virg	zinia	
	pue *		Usual Residence of Dece 10a. State 10b.	County		10c. Cit	y, Town or Lo	cation					_		10d. Inside Cit	y Limits
	Mary	ğ	MD Pr	ince G	eoroes	Car	citol He	idhts							1. Yes	2 🗌 No
	ours effer death with the Marylend rel', or items 23a or 28a-f ehow Examiner must be notified at	Funeral Director	10e. Street and Number					10f. Zip	Code			1	l0g. Citiz	en of What Co	ountry?	
	h with	<u>a</u>	1900 Grovewoo	d Drive	2				20743				Unite	d States	5	
	death	ner	11. Marital Status		12. Was Deced	lent Ever in U.	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spec	ify Yes or No- ican, etc.)	1	4. Race - Ame Black, Whit		
9	of te		1 Never Married 2		1 ☐ Yes 2	2 ∑ No		1 ☐ Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	,			ack	
21215-0036	72 hours efter "natural", or ite	d by	3 Widowed 4 □ D		Year or Da	tes:										
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an	should be ind Mental marked o	To B	Emitt Braces	7						Bett	y Johr	rson				
Maryland	s 1 and 2 should be filed withi f Heelth end Mental Hygiene. Item 27 is marked other than other treumatic event, the M		19a. Informant's Name/R	elationship	(Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Rural	Route Number	r, City or	Town, State, 2	Zip Code)	
	and 2 belth of 27 i		Cecelia White	<u> </u>	Daughter		1900_G	coveva	od Dr	ive. C	apitol	Heights	, Mar	yland 2	0743	
Ore	m 0		20a. Method of Disposition		□Removal from S		Place of Dispo semetery, crer	sition (Nam	e of		Da	te	20c. Loc	ation - City or	Town, State	
Ĕ	Page ment o ant: If ury or		`4 □Donation 5 □				verdale	Cremeto	ory	0	8/23/2	2005	River	dale, Ma	ryland	
Baltimore,	permit. Page Depertment Importent: If any injury or once.		21. Signature of Funeral	Service Lice	nsee	ON	22	. Name and	d Addres	s of Facility	y John	T. Rhin			•	
ш_	20E = a		23a. Part1. Enter the dis	an	Smel	9		015 12	th St	ræt, i	NE W	shington	, DC	20017	Approximate	
	rnysician /Medical Examiner	ner	shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia	ſ	a. Cardio Due to (o	Pulmonal or as a conseq	uence of): y Diseas								Interval Betw Onset and D	reen eath
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oʻ	be executed sicien and burial-transit		resulting in death) Last			r as a conseq										
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	gned be de	þ	Part II. Other significant End Stage Rev	2007	772 -271 -20	ath but not res	ulting in the u	ndertying ca	use give	n in Part I.			beccous es 2.1∑		the cause of de	ath?
Ö	w requir been si should I	etec											-		dense findings o	
Division of Vital Records,	The lay ete hes page 2	Completed	Prephral Vaso	ular D	isease							24a. Was a autops perform	sy	prior to death?	topsy findings a completion of ca 2 ☐ No	use of
/ita	Physician: this certific ral director,	Be	25. Was case referred to examiner?	medical	Literaitel				04		of Death	(Check only on	(8)			
=	Physic this c	၉	1 ☐ Yes 2 ☐ No				ER/Outpatien		-	+ CX I Va		e 5 🗆 Reside			cify)	
ü	ding F h. After funera	Certification:		Pending	137	Day Year)	28b. Time of Injury	м 2	9c. Injury Work 1 □ \	at :? /es 2.⊟1		d. Describe ho	ow injury	occurred		
is:	Attending r death. sctor: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	De Oleon	of Injury - At ho	ome farm str			103 2		af. Location (Si	reet and	Number or Ru	ıral Route Numb	er.
Òį	or A after Direct	er E	4 🗌 Homicide	determined	buildin	g, etc. (Specif	y)	501, 145151	, 011100			City or Town	n, State)			,
	To the Hospital or Attenswithin 24 hours after deatl To the Funerel Director:	edical C			hysician: To the l miner: On the ba and manne	sis of examina										
	To the within ? To the comple	Mec	29b. Signature and title of	f certifier				29c.	License	number		2		signed (Monti		
	->-0		> BW	NW	8)			J	515	20			08	-19-2	005	
R			30. Name and address of													
	Sta	to.	Bahram Pis 31. Date filed (Month, Da	hoad. M	D 9801 G	orgia Av	tenue, S	ilver 8	prin	y, Mary	yland	20902				
	Registr		31. Date filed (Month, Da AUG 2	4 200!	Section	n K		W								

DHMH 17 Rev 1/2001

		For State of Maryland / Del	oartment of Health and Me <i>rtificate of Death</i>	lental Hygie Reg.	ⁿ ² 2005	2934				
Physicia		Decedent's Name (First, Middle, Last) WALTER JUNIOR GREEN		2. Date of Death Month August 1		3. Time of Death				
/Medic Examin		4a. Facility Name (If not institution, give street and number) 5000 Lydiannia St. #315 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Suitland y) If Under 1 Year If Under 24 Hrs.	P	4c. County of Death	ge's				
Funeral Director		229 50 4258 XXM 2□F 64 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sep. 17,	1940 Vir	lace (State or Fore try) ginia				
which is a nous aries obstrivent the maryland than "natural, or tems 23s or 28a-f show is Modical Exaciliter must be notified at	Director	Maryland Prince Gecerge's Suitla		100	Citizen of What Coun	0d. Inside City Lim 1 X Yes 2 □				
ns 23e o	Funeral D	5000 Lydiannia St. #315 11. Marital Status 12. Was Decedent Ever in U.S. 13	20746		USA 14. Race - America					
ral', or her	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed XX Divorced Armed Forces? 1 ☐ Yes 213 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelif Yes, specify Cuban, Mexican, Puerto □ Yes XX No Specify:	Rican, etc.)	Black, White, e	etc.				
power. Tages I said as about to me while refined aners are regain with the wayran beauthent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-1 show any injury or other traumatic avent, If a Modical Exercitret must be notified at once.	Completed	(Specify only highest grade completed) (Gir Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired) DOK Binder	ng	Designation	lustry				
kad othar	To Be Co	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name	(First, Middle, Maid	Private					
h and M	_	19a. Informant's Name/Relationship (Type, Print)	Grace G	l Route Number, Cil						
ont of Healt It: If itam 2 y or other		20a. Method of Disposition XIX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cr	ematory or other place)	ate 20c.	rings, MD . Location - City or Tov	wn, State				
Departme Importan any injur- once.		21. Signature of Funeral Service Licensee	etion Cemetery 08/2 22. Name and Address of Facility Marshall's Funeral 2308 Suitland Road	Home of M	Clinton, Maryland, i					
rysician Medical	1	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Cardiomyopathy resulting in death)				Approximate Interval Between Onset and Death				
xaminer and the prijal-transit	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): Hypertension									
physicia the bu	dicai	resulting in death) Last Due to (or as a consequence of): d. Diabetes Mellitu	S							
ed by the attending detached for use as	by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year				
		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the					
ate has page 2	Completed			24a. Was an autopsy performed 1 Yes 3	death?	pletion of cause				
his cer	ation: To Be	25. Was case referred to medical examiner? **X**Yes 2 No			6 ☐Other (Specify) jury occurred	un;				
s after death	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	8f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,				
in 24 hou he Funar pletely fill	ledical	29a. Certifier (Check only one) XX Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date a	ind place, and due to t	the cause(s)				
within 24 hours a To the Funaral t completely filled	~	29b. Signature and title of certifier Description	29c. License number D17729		Date signed (Month, Di 1gust 19, 2					
12)	1	30. Name and address of person who completed cause of death (Item 23a) (Type		At	agust 17, A	2007				

			1- State of Marylar Registrar	nd / Departr	ment of He	ealth and M	lental Hy		20211
· d	Physici	an	1. Decedent's Name (First, Middle, Last)	1	icate of D	Jeain	2. Date of Dea	Day Year	29344 3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Suburban Nogpila			Location of Death	7103	2/ 2005 4c. County of Death Months	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F 78 78		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan • 19		place (State or Foreign
	Maryland f show	lor		ity, Town or Location	on				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28a at 5e notii	al Director	100. Street and Number 13129 Beaver Terrace		Of, Zip Code	53		10g. Citizen of What Cour United Sta	*
-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene marked other than "natural", or Items 23s or 28s-f show imatic event, the Midical Expriment, mat be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes		spanic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
215	within 72 ho ene. than "natur in N. cical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			tion uring most of worki	ng	16b. Kind of Business/In	dustry
e, Jeo (a) 03 /land 21	should be filed within and Mental Hygiene. In a Mental Hygiene. In arked other than matic event, the Mentalic event.	To Be Co	12 17. Father's Name (First, Middle, Last) Aubrey Nauss	ноше	maker	18. Mother's Name		Own Home	
nause 1105 B. Maryl	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) David A. Greenhause / Son	910 Lea	fy Hollo	ow Circle	Mt. A	r, City or Town, State, Zip Airy, Maryla:	nd 21771
Freenh (P: 813 altimore,	Pages nent of ant: If it ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Free	Place of Disposition cometery, cremator Cederick C	ry or other place, remator) Augus		20c. Location · City or To Frederick, M	aryland
Ba egg	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee	8 E.	. Ridgev	ville Blv	d. Mt.	Funeral Home Airy, Maryl	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	al be		ma	Toophiatory and		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	tra	uma	0		P'	かち
760,	te be executed ysician and ne burial-transit	cal Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a conse	juence of:			292	22/05	
P.O. Box 687	n certifica anding ph use as th	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1. □ Yes 2 No 9 □ Unknown	ıl death 3 ⊟Ectő	paic pragnancy er (specify)	*)		23d. Date of delive Month	ory Day Year
ords, P.	w requires that the deatt been signed by the atte should be detached for		Part II. Other significant conditions contributing to death but not resi	ulting in the underly	ying cause given	in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
Division of Vital Records,	: The law re cate has be ; page 2 sho	Completed					24a. Was a autops perform	sy prior to cor med? death?	psy findings available appletion of cause of
V it	nding Physician: Th th. : After this certificate s funeral director, pag	To Be	25. Was case referred to medical examiner? 1XYes 2 \subseteq No Hcspital: 1Xinpatient 2 \subseteq	ER/Outpatient 3	□ DOA Other:	26. Place of Death		nel ence 6 □Other (Specify	
n of	ing Ph	on: T	27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at 2		ow injury occurred	- 10
Divisio	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 286 Place of Injury - At hobiding, etc. (Specification)	ome, farm, street, fa		2 2 No /	8f. Location (Si City or Town	treet and Number or Rura	Route Number Begrer Tern
	Hospitu 4 hours Funera tely fille	Medical C	(Check only one) 13. Certifying Physician: To the best of my known one) 2 Medical Examiner: On the basis of examinal	wiedge, death occi	urred at the time. jation, in my opir	, date and place, a non, death occurre	nd due to me ca	200000	ated.
	To the within 2 To the comple.	Med	one) and manner stated. 29b. Signature and title of certifier.	1	29c. License r			9d. Date signed (Month, I	
	20		30. Name and address of person who completed cause of death (Item	F3a) (Type, Print)	D42181	1		August 21,	2005
	90		Enrique Daza, M.D. 106 Irvin 31. Date filed (Month, Day, Year) 32. Regis Ar's Signa	g Street	,NW Was	shington,	D.C. 2	20010	
	Stat Registra		AUG 2 4 2005	J. H. A	colle				

			1 - For State Registrar	Stat	e of Mar	-	partment of I ertificate of		nd Mental		ne 200	5 29345	
	Physici /Medi	cal		omas	G.		Garcia		Mont Augus		Day Yea 2005	6:02 A M	
	Examir	ner	4a. Facility Name (If not institute Southern Marylands) 5. Social Security Number	d Hospital		Un ura laat hirth de	4b. City, Town, Clinton (V) If Under 1 Year	or Location of			4c. County of De Prince Geo	rge's	
	Funeral Director		217–61–4363 Usual Residence of Decedent	6. Sex 1√√21/11 2□		In yrs. last birthda 57 Yrs.	Months Days		Min. Sept.	h, Dey, Ye	947 Phi	irthplace (State or Foreign Country) Lippines	
	ie Maryland Ba-f show diffed at	ector	10a. State 10b. Cour Maryland Princ	te George's		Oc. City, Town or Clinton						10d. Inside City Limits 1 ☐ Yes 22€No	
	ath with the 23a or 2 ust be ris	Funeral Director	10e. Street and Number 8600 Mike Shapii	ro Drive	#214		10f. Zip Code)735		10g.	Citizen of What (Country? Lippines	
980	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or itams 23a or 28a-1 show event, if a Mexical Exerciter cast be tredified at	by	11. Marital Status 1 □ Never Married 2∰23/M 3 □ Widowed 4 □ Divorc	Arme arried 1 ☐ If Ye	Decedent Eved Forces? Yes 2 XXNos, Give	er in U.S.	3. Was Decedent of I If Yes, specify Cub 1 Yes 2XXNo	an, Mexican,	in? (Specify Yes Puerto Rican, etc	or No- c.)	14. Race - An Black, Wh Specify: F	nite, etc.	
21215-0036	filed within 72 ho Hygiene. other than "natur ant, Ita Medical	Completed	15. Deced (Specify only high Elementary/Secondary (0-12)	ent's Education hest grade comple) 4	eled) ege (1-4or 5+)	(Gi	pedent's Usual Occupive kind of work done to DO NOT use retire	during most ad)	of working		o. Kind of Busines	s/Industry	
Maryland 2	should be filed of Mental Hygis markad other matic evant, II	To Be C	17. Father's Name (First, Middle Juan Garcia	e, Last)					's Name <i>(First, M</i> lara Garci		den Sumame)		
	nd 2 sh lth and 27 Is m		19a. Informant's Name/Relation Jesse G. Garcia			4426	iling Address (Street Natahala Dr	ive Cli			ity or Town, State, 20735	Zip Code)	
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 □ Crematio '4 □ Donation 5 □ Other	(Specify)	ITOTII State	Laloma C		Aug	Date gust 30,0)5 Ph	: Location - City o	S	
Bal	permit. Departr Imports any inj		21. Signatule of Funeful Servi	S		(22. Name and Addre	II Road	Oxon Hill	, Mary	<u>rland 20</u>)745	
	Pnysician /Medical Examiner	_	23a. Part. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	Condi	consequence of):		ng, such as c	ardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death	
68760,	licate be executed physician and s the burial-transit	Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): A PLAT is											
P.O. Box 6	law requires that the death certifinates been signed by the attending tashould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 🗀 L 4 🗀 F	s, outcome of live birth 2 (Pregnant at tin Unknown	Fetal death	B Ectopic pregnanc D Other (specify)	у			23d. Date of de Month	elivery Day Year	
	w requires that been signed b should be deta	by	Part II. Other significant cond	tions contributing	to death but i	not resulting in the	underlying cause gr	ven in Part I.				to the cause of death? Probably 4.\times\text{Unknown}	
of Vital Records,	The ate h page	Completed							1 D Y		? prior to death?		
/ Vit	Physician; this certific ral director,	o Be	25. Was case referred to mediexaminer? 1 ☐ Yes 2 ত 対	Haspital	1 🖾 Inpatient	2 ER/Outpati	ent 3 DOA Oth		of Death (Check of		6 □Other (Sp	ecity)	
	Attending Ph ir death. actor: After th by the funeral	ation: T	Z Addidont	ding stigation	Date of Injury Month, Day Y	28b. Time Injury	Wo		28d. Desc		njury occurred		
Division	P # F =	27. Manner of Death XX Natural 2								ion (Street r Town, St	t and Number or F tate)	Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	l edical	(Check only 2 Medic one)	el Examiner: On t and	o the best of r the basis of ex manner states	camination and/or	ath occurred at the til investigation, in my o	pinion, death	place, and due to n occurred at the t	ime, date i	and place, and du	e to the cause(s)	
0	S o o o	W	29b. Signature and title of certi	Dan	2	im.	29c. Licens			29d.	Date signed (Mon	on, Day, Year)	
_	(3)		30. Name and address of person Khosrow Davac					inton. N	Maryland	20735	- 1	•	
	Sta Registr		31. Date filed (Month, Day, Yea AUG 2 4	ar)	2. Registrar's	Signature	de .	,					

December December				1 - For State Registrar	State of Ma	ryland / D	epartment of I Certificate of	Health and M <i>Death</i>		ene 2005	29346
Marguerite Flizabeth Hood August 13, 2005 5:15pm August 13, 2005 S:15pm August 13, 2005 Au		Dhusisi			t)				2. Date of Death		3. Time of Death
Chetry Lane Mursing Calter Prince The Corges Solve Supply Income and Number The Corp Solve S	Se					n Ho	od			,	5 5:15P ^M
The control of the co		Examir	er		ŕ		4b. City, Town,	or Location of Death			
The state of the s		Euperal		Cherry Lane Nu 5. Social Security Number 6. Se			hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince	Georges
Use State and Processing Control of Contro				577-38-5355	□ M 251F	80 1	rs. Months Days	Hours Min.			
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Physician Medical Examiner Part Compared to the compared				23a. Paryl. Enter the disease, or comp	lications that caused th	e death. Do no	3910 S11	VER Hill ng, such as cardiac or	Rd., S	uitland	
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23c. If yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1	2/0	ate be hysicia	Icai	(d						
Section Part Other significant conditions contributing to death but not resulting in the underlying cause given in Part		ding b			230. If yes, outcome of	pragnaga					
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24a. Was an autopsy performed? 24b. Were autopsy findings available profit to completion of cause of death? 25c. Place of Death Check only one 25c. Place	S,	es tha igned be de	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in	he underlying cause giv	ren in Part I.	23e. Did tobac	co use contribute to	the cause of death?
25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death Check only one) 27. Manner of Death 1 Not stiglation 28. Date of Injury 28. Date of Inj	פבס	requir	eted	Datal	es AV	Cell	le 5		1 Tes	2 10 40 3 Pr	obably 4 Unknown
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30. Name and address of person who completed cause of death (Item 23a) (Type Print) 5 16 SASUL 14333 LAUREL FOW TO Red. St 208 LAUREL MY 2070 8 State 31. Date filed (Month, Day, Year) 28. Registrar's Signature		ospita hours uneral	Saic	29a. Certifier 1⊠ Certifying Phy	sician: To the best of r	ny knowledge,	death occurred at the tin	ne, date and place, ar	nd due to the cause	e(s) and manner as	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type Print) 5 16 SASUL 14333 LAUREL FOW TO Red. St 208 LAUREL MY 2070 8 State 31. Date filed (Month, Day, Year) 28. Registrar's Signature		the H nin 24 the Fu	ledic	0.107	and manner state	amination and/ i.	or investigation, in my o	pinion, death occurred	d at the time, date	and place, and due	to the cause(s)
State 31. Date (iled (Month, Day, Year) \ 28. Registrar's Signature		viil Con	2	290. Signature and title of certifier	-	0 1	29c. Licens	e number	290.	Date signed (Month	Day Year)
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			1 - For State Registrar	State o	f Maryla		artment of H tificate of L		-	giene Reg. No.	005	29347
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De		V	3. Time of Death
	Physici /Medio		Marquerite Le	nore Hami	1ton_				08	18 ^{Day}	2005	11:39 PM
	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of Deat	h	4c. Co	ounty of Death	
			MSouthern Mar	A			Clint				ince Geo	orge's
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	h y, Ye <i>ar)</i>	9. Birtho	lace (State or Foreign
	Director		579-32-0637 Usual Residence of Decedent	-X	09	115.			08 30	1915	Vir	ginia
	land		10a. State 10b. County		10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sh	to	DC		Wa	shingto	n					1 XYes 2 □ No
	the 7.28a	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cour	itry?
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	ms 2	Funerai	11. Marital Status		edent Ever in	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S	pecify Yes or No	- 14.	14. Race - American Indian,	
980	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Modical Examinet must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	If Yes Gir	2 <u>X</u> No ve		rYes, specify Cuba I⊡Yes 2. Mar No	n, Mexican, Puerl Specify:	o Hican, etc.)		Black, White, pecify: Black	_
9-0	72 ho	ted	15. Deceden	t's Education		16a. Deced	lent's Usual Occupa	ation	tina	16b. Kind	of Business/Inc	dustry
215	d within 72 ho giene. Ir than "natui Ir e Madical	ηpie	Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life. L	kind of work done of OO NOT use retired	uring most of woi	King			
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Ind	0 to 0	Be	17. Father's Name (First, Middle,	,					ne (First, Middle,	Maiden Su	ımame)	
yla	should by	70	Robert Stewar			405 44 75		Virgie				
, Maryland 21215-0036	nd 2 :		19a. Informant's Name/Relations Deborah William				g Address (Street a Sherman	Ave., N.				
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Ctoto	Place of Dispo cemetery, cren ashingto	sition (Name of natory or other place on Nation	al 08/2	6/2005		tion - City or To Lland, N	
Balt	21. Signatural Service Licensee 22. Name and Address of Facility I							ia Ave N	atney's W; Washi	nator		
			23a. Part1. Enter the disease, or spock, or hear railure. List	complications that o	eused the dea	ath. Do not ente	er the mode of dying	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	7	tente 1	Munce	Mags I	of Entry				Onset and Death
	/Medical		resulting in death)	Due to	(or as a conse	equence of):	2	11-00 01 (04				
L	Examiner		Sequentially list conditions	b	Corunan	anten	Desense					
	₽ .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse	equence of):						
	ecute ind trans	Examine	that initiated events	c								
30,	oe exectan a	Ě	resulting in death) Last	Due to	(or as a conse	equence of):						
8760,	cate be executed physician and the burial-transit	dicai		d								
9	ding page as	_ O	IF FEMALE:	23c. If yes, out	learne of program	2224						
Вох	death certific e attending p d for use as I	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live b	oirth 2 ☐ Fei nant at time of	tal death 3 🗌	Ectopic pregnancy Other (specify)			230	 Date of delive Month 	ry Day Year
o.	that tha de ad by the a detached t	Physician/M	1 □ Yes 2 ⊡*No 9 □ Unknown	9☐Unkn		death 5	Other (specify)					
<u>α</u>	that is detail		Part II. Dther significant condition	ons contributing to de	eath but not re	sulting in the ur	iderlying cause give	on in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
Vital Records,	requires that een signad b hould be deta	d by							1 🗆 Y	es 2 🗹	√o 3 □ Proba	ably 4 Unknown
000	> 4	iete							24a. Was	an 2	Ab Were autor	osy findings available
Re	0 5 0	Completed				············			autop perfor	SV	prior to con death?	npletion of cause of
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5	Physician: this certific al director,	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2[⊇ER/Outpatien	3 □ DOA Othe		th Check onl of		70thes (Co-sit	
of		-	27. Mann of Death	28a. Date	of Injury	28b. Time of	28c. Injury	at	ome 5 Resid			9
lo	Attending r death. ector: After by the fune	tio	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	9	th, Day Year)	Injury	Work M 1⊟Y	? ′es 2 □ No				
Division	I or Attendi after death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could i	ined 286. Place	of Injury - At I	home, farm, stre	et, factory, office		28f. Location (S		lumber or Rural	Route Number,
Ö	s after al Dire	Certification:	4 Hornicide	Dulidi	ng, etc. (<i>Spec</i>	iny)			City or Tow	n, State)		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai (29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the band man	best of my kr asis of examin ner stated.	nowledge, death nation and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, c	ause(s) and date and pla	d manner as sta ace, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and the o certifie	r			29c. License	number	2	29d. Date s	igned (Month, L	Day, Year)
6	7		Name	MD			0005	5120		Hugu	it 19 2	ev 5
(1/2)		30. Name and address of person limaril Palmer	who completed caus	so of death (Ite	om 23a) (Type, I			hiba DC	2003		
	Sta		31 Date (iled (Month, Day, Year)	32. R	egistrar's Sig	ature			-			
	Registr	ar	AUG 2 J 2003	The same of	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Joseph Lee Helber August 2005 11:20 p.m /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7-14-1918 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Days Min 1**∑** M 2□ F Months Hours Yrs. Director Missouri 486-16-1105 87 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28e-f show 1 ☐ Yes 2 No MD St. Mary's Director Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45600 Stoney Run Drive 20634 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: White à 3 Widowed 4 □ Divorced al Hygiene. d other then "nature went, it e Modical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Engineer Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lent: If Item 27 is marked ott Be Lena Victoria Horton John Westley Helber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45600 Stoney Run Drive, Great Mills, MD 20634 Linda Lou Brown/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Cepartment of H
In portent: If Ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Cre 8-27-2005 4 □ Donation 5 □ Other (Specify) Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Fune Service Licensee 22955 Hollywood Road, Leonardtown, MD 20650 M01206 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has le 2 autopsy performed? page certificate 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4. Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier l 🐻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. (Check only one) 29b. Signature and title of d 29c. License number 29d. Date signed (Month, Dey, Year) of death (Item 23a) (Type, Pfint) 30. Name and address of person who completed cau-James P. Jatboe, 24035 Three Notch Road, Hollywood, MD 20636

Registrar

State

31. Date filed (Month, Day,

Year)

AUG 2 9 2005

32. Registar's Signature

Physician	1. Decedent's Name (First, Midd	dla Laat)			e of De				~ ~	C J U 7
		ne, Last)					2. Date of Dea			3. Time of Death
	Clyde	Titus	Hess				Month August	28, 20	Year O.5	8:35 a.m
/Medical Examiner		on, give street and nur		4b. City.	Town, or Lo	cation of Death		4c. Count		0:33 a.n
_xamo.	24175 Point L	ookout Roa	d	_	eonar	_			Mary'	_
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. last birti	hday) If Under	1 Year If	Under 24 Hrs.	8. Date of Birt			S place (State or Forei
Director	162-28-6400	1 ∄ M 2□F	70	rs. Months	Days I	Hours Min.	(Month, Da) Aug. 2	v. Year)	Cour	ntry)
D	Usual Residence of Decedent						Aug. Z	, 1900	rem	sylvania
show ad at	10a. State 10b. Count	у	10c. City, Town	or Location					1	I0d. Inside City Limi
72 hours after death with the Maryland natural, or Items 23a or 28a-1 show acal Examinating at the notified at each by Funeral Director	Maryland St	. Mary's		Leon	ardto	r.m				1 🗋 Yes 2 🖪 N
with the Mark t or 28a-1 s be notified Director	10e. Street and Number	· mary b		10f. Zip		WII		10g. Cîtizen of	What Cour	ntry?
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172 hours after death with the Maryla "natural", or Items 23a or 28a-1 show cleaf Ex utrar in ust be notified at leted by Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.S.	13. Was Deced	206 ent of Hispa		ecify Yes or No-	United 14 Bar	Stat ce - Americ	
Fun	1 ☐ Never Married 2 ☐ Ma	Armed Fo		If Yes, spec	ify Cuban, M	Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ck, White,	
urs a al', o by	3 ☐ Widowed 4 ♣ Divorce	If Yes Giv	re	1 ☐ Yes 2	No S	pecify:		Specif	y Whi	te
ed sture	15. Decede	nt's Education		Decedent's Usual	I Occupation	2		16h Kind of B		4
	(Specify only high	est grade completed)		(Give kind of worldife. DO NOT us	k done durir e retired)	ng most of work	ring	16b. Kind of B	usinessini	dustry
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men tant:	'4 □ Donation 5 □ Other (Specify)	Brinsfi	eld-Ech				harlot	te Ha	11, MD
Department of Important: If any injury or once.	21. Signature of Funer J Service	Licous		22. Name and	Address of	Facility Br	insfield	Funera	a 1 Hor	me, P.A.
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~	30 Name and address of server									
5	30. Name and address of person	- /								
State	30. Name and address of person William D. Boyd 31. Date filed (Month, Day, Year)	II, M.D.,	25365 Poil gistrar's Signature		ut Ro	ad, Leo	nardtown	ı, Mary	land	20650

			For State Registrar	State of Maryland	Cei	tificate	of D	eath	ivientai H	ygien Reg. N	2005	5 29350
	Physici /Medic	al	Decedent's Name (First, Middle, Last Avey Lo 4a. Facility Name (If not institution, give	uise Haley		4b City T	own or l	ocation of Dea	2. Date of I Month AUGUS	Г 30.	ay Yea	10:25A M
	Examin Funeral Director	ier	St. Mary's Hospit 5. Social Security Number 6. Se	a1 x 7. Age (In yrs. Ia	st birthday) 77 Yrs.	Lec	nard	town If Under 24 Hrs Hours Min	6. 8. Date of E	Birth Day, Year	St. Mar	
	f show	or	Usual Residence of Decedent 10a. State 10b. County		Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
4	inous and beart with the marylative ture!; or tems 23s or 28s-f show at Ever it we invalided at	ral Director	Maryland St. Mary 100. Street and Number 26380 Hill & Dale Road		lywood	10f. Zip (10g. C	itizen of What	
036	el', or Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Vas Decede fYes, speci I□Yes 2		panic Origin? (S Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	No-	Black, W	merican Indian, hite, etc. White
Maryland 21215-0036	"ne	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	life. L	kind of work OO NOT use	done dui retired)	on ring most of wa	rking		Kind of Busine	ss/Industry
lang z	snough be med with ind Mental Hygiene. s marked other ther umetic event, the M	Fo Be Co	17. Father's Name (First, Middle, Last) James Henry Burch		Produc	ts Asse			me (First, Midd therine M	le, Maidei	ectrical n Sumame)	
e, Mary	Health and Mental		19a. Informant's Name/Relationship (T) Harold L. Haley / Hus	band	26380	Hill &	Dale :	d Number or R	ural Route Num	nber, City Maryla	and 2063	6
Baitimore,	ntmen rtent:		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	f Charl	ce of Disponentery, crem		arden	s 2, 2	Date tember 2005			or Town, State Maryland
מ	Depa Impo		23a. Part I Enter the disease, or compleshock, or heart failure. List only o	Hardiner	Ma P.	ttingle O. Box	y-Gar 270,	diner Fu Leonardio	neral Homown, Mary		Å 20650	Approximate
	nysician /Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a constitue	C	070						Interval Between Onset and Death
GO / GO,	7 =	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque								
the death con		Completed by Physician/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② Mo 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pred Other (spec					23d. Date of o	lelivery Day Year
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To the Hospital or Attending	urs after de ral Directo lled in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)					City or To	own, State	9)	Rural Route Number,
the Hoen	within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 2 Medical Examination (Check only one)	sician: To the best of my knowledger: On the basis of examination and manner stated.	edge, death n and/or inv	estigation, ii	the time, my opini	ion, death occu	o, and due to the urred at the time	, date and	d place, and di	as stated. ue to the cause(s) nth, Dey, Year)
ř	SHE	_	30. Name and addr s of person who co	mpleted cause of death (from 3	3a) (Tuno 5	1		5575	-1			2005
1	Sta	te	JENNIFER SCHMIDT, 31. Date filed (Month, Day 1979)		REE N			CALIFO	ORNIA, 1	MD 20	0619	

AVEY LOUISE HALEY

05-05670 Hank William Honeycutt **RJD**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	, TTTTCIII		1 - For State Registrar	State of Man		artment of his rtificate of				29351
			Registrar 1. Decedent's Name (First, Middle, Las	st)		runcate or	Death	2. Date of Dea	th	3. Time of Death
	Physici		Hank William Ho					Month August	Day Year	0601 A. M
	/Medic		4a. Facility Name (If not institution, give	street and number)		4b. City. Town, o	or Location of Death	August	4c. County of Dea	
	Examir	er	6150 Taneytown P			Taneyto			Carrol1	
	Funeral		5. Social Security Number 6. S	ex 7. Age (/	n yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		thplace (State or Foreign
	Director		212-62-4381	ZM 2□F 5	2 Yrs.	Months Days	Hours Min.	June 1	8.1953	MD
_	p .		Usual Residence of Decedent 10a. State 10b. County	14	Dc. City, Town or L	onation			,	10d. Inside City Limits
	anyla ehon	٦			oc. Only, Town of E	ocation				1 ZYes 2 No
	he M	Director	MD Carro)11	Taney	10f. Zip Code			l 0g. Citizen of What C	
	172 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow edical Examinar must be notilied at	١	82 Carnival Dri	lve		2178	7		USA	ournry!
	death	Funeral	11. Marital Status	12. Was Decedent Eve	or in U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
9	or Ite	교	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 Yes, specify Cub	an, Mexican, Puerto Specify:	Hican, etc.)	Black, Whi	
21215-0036	ral, c	d by	3 Widowed 4 Divorced	Year or Dates:		TO THE ZIZINO	Specify:		Specify:	White
5	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup kind of work done	during most of work	ring	16b. Kind of Business	•
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22	filled v Hygie ther i		12 17. Father's Name (First, Middle, Last)		<u>In</u>	staller	18. Mother's Nam		Janf.Buil Maiden Sumame)	ding
Maryland	a la b ≥	9 Be	Charles W.Honey	•			Buna Ho		,	
$\overline{\leq}$	d 2 should th and Men 7 is marke traumatic	ို	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street		-	r, City or Town, State,	Zip Code)
S	Ith ar Ith ar 27 is r trau		Buna Honeycutt		1	-			WN, PA	
ē,	f Healt f Healt frem 2 other	13	20a. Method of Disposition		20b. Place of Disp		-		20c. Location - City or	
Baltimore,	t. Pege rtment o rtant: If		1 Burial 2 Cremation 3 □ 4 □Donation 5 □ Other (Specify				' 1	3/25/05	Pleasant	Valley,M
a E		- 1	21. Signature of Funeral Service Licen			2. Name and Addre	see of Excility			J
m	Depariment of the parameter of the param		Kuhan	of Litte	le y. 11	ttles	rп 34 Ма	apre, Av	e.Little	stown,PA1
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the	e death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	N	luttole in	niunes				Onset and Death
	/Medical		resulting in death)	Due to (or as a c	onsequence of):	9 001103				
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	p ii	Examiner	Sequentially list conditions, if any, leading to initional diate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a o	unsequence of):					
	cate be executed physicien and the burial-transit	каш	that initiated events resulting in death) Last	c Due to (or as a c	oncoguence of					
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			IF FEMALE:	23c. If yes, outcome of p	regnancy				23d. Date of de	livon.
Вох	death certif e attending id for use as	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 (4 Pregnant at tim	Fetal death 3	☐Ectopic pregnanc	у		Month Month	Day Year
o.	thet the de led by the a detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
s, P	es thet Igned b	by PI	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	the cause of death?
rds	requires een sign hould be							1 🗆 Y	es 2 No 3□P	robably 4 Unknown
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Re	o = 5	E						autops perform	med? death? 2 No 1 Y Yes	completion of cause of 2 □ No
Vital	ician: Th certificate ector, pag	S S	25. Was case referred to medical				26. Place of Deat			2010
>	S S D	To B	examiner? 1 ⊠ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Ot	ner: 4 Nursing Ho	ome 5 Reside	ence 6 Other (Spe	cify) (scene)
n of	ding Ph h. After th funeral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	28b. Time o	f 28c. Inju	ry at		ow injury occurred (over in number
Ö	Attending r death.	atic	2 Accident investigation	82205	5:50		Yes 2 No	venice a	oilision	
Division	for Attendation of the Control of th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State) mi) 140	ural Route Number, West of
۵	oital c urs af ral D				road			hiphsi ka.	yaneytoron, n	(1)
	• Hospital or a 124 hours after • Funeral Direction of Funeral Direction of Funeral Direction of the filled in Expension of the Expension of t	edical	(Check only 22 Medical Exam	ysician: To the best of n niner: On the basis of ex	amination and/or in	th occurred at the till evestigation, in my o	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the Hose within 24 ho To the Func completely f	Med	29b. Signature and title of certifier	and manner stated	l.	29c. Licens			9d. Date signed (Mon	
	5 <u>₹</u> ₹		1 10			0-C-1			August 22.	

Famula Street, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore Maryland 21201 Pamela E. Southall, MD
31. Date filed (Month, Day, Year)
33. State

AUG 2 4 2005

Registrar

O.C.M.E.

29d. Date signed (Month, Day, Year) August 22, 2005

State of Maryland / Department of Health and Mental Hygiene 2005 29352 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** Charles Russell Hovermale 12:30 Pm August 24,2005 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Julia Manor Nursing Home Hagerstown, Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar.19,1913 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑** M 2□ F 220-10-3238 92 Director MD Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Washington Hagerstown 1 ☐ Yes 2 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11825 Linbar Dr. 21742 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: Specify: White 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Be Completed by 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 8th grade College (1-4 or 5+) railroad Train Service 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pendleton Hovermale Lorinna G. Ambrose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) son Terry R. Hovermale 19504 Thomas Dr. Hagerstown, MD 21740 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Suriel 2 Cremetion 3 Removal from State Clear Spring, MD St. Paul Cemetery 4 Donetion 5 Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Donald Edwin Thompson Funeral Home, Inc 23e. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximately a such as cardiac or respiratory errest,

Approximately a such as cardiac or respiratory errest,

Approximately a such as cardiac or respiratory errest, Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Physician/Medical Examiner 035 attending physicien end for use as the burial-transit or Attending Physician: The law requiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? within 24 hours effer death.

To the Funerel Director: Affer this certificate I complataly filled in by tha funerel director, peg 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medicai Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 70060396

DHMH 16 Rev 6/95

State Registrar

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08/25/05

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30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 1/2 &

32. Registrer's Signeture

Chelin

MUNCHED

31. Dete filed (Month, Day, Year)

			1 - For State of Maryland		artment of I			iene	
	Physic /Medi		Decedent's Name (First, Middle, Last) Douglas David HAYES				2. Date of Deat Month	700	5 32 in 90 go fg 3
	Examir		4a. Facility Name (If not institution, give street and number) 19617 Old Forge Road		Ha	or Location of Death	1	4c. County of De	
	Funeral Director		5. Social Security Number 220-58-3645 Usual Residence of Decedent	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 26		Birthplace (State or Foreign Country) aryalnd
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event; I've Medical Eventing must be notified at ange.	by Funeral Director	10a. State 10b. County 10c. City, T Maryland Washington 10e. Street and Number 19621 Old Forge Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	13.	Hagerstov 10f. Zip Code	VN 21742 Hispanic Origin? (S an, Mexican, Puerti Specify:		USA 14. Race - Ar Black, WI Specify: W	nerican Indian, nite, etc.
nd 21215-0036	a filed within 72 ho il Hygiene. other then "natur. vent, I're Medical.	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 17. Father's Name (First, Middle, Last)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of word	king 1	6b. Kind of Busines farmin (aiden Sumame)	•
Maryland	d 2 should be th and Menta 7 is markad traumatic av	To B	Thomas William Hayes 19a. Informant's Name/Relationship (Type, Print) Emma Chaney — sister			Madelin	ne Cornel	ia Hatfie	, Zip Code)
Baltimore, I	permit. Pages 1 and Department of Healt Important: If item 2 any injury or othar once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place ceme	of Dispo etery, cren Have	sition (Name of natory or other place on Cemete Name and Addre	ery 8/27	Date 2 7/05 H INNICH FU	NERAL HOM	or Town, State a, Maryland IE
8760,	Physician and /Medical Examiner is the burial-transit	ai Examiner		o not entered on the office of	er the mode of dyin	Ison Blvd	or respiratory arres	stown, Mo	Approximate Interval Between Onset and Death
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ords, P.	w requires that baen signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.	1	_	to the cause of death?
al Record	The law ate has b page 2 s	Completed					24a. Was an autopsy performe	ed? prior to death?	autopsy findings available completion of cause of s
sion of Vital	ling Phys 1. After this Tuneral di	ation: To Be	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Outpatient Time of Injury	28c. Injun Work	er: 4 ☐ Nursing Ho	h (Check only one) me 5 Resident 28d. Describe how	ce 6X Other (Spe	second ecifyresidence
Division	Dir	i Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)				City or Town,	ŕ	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled 2 Medical Exeminer: On the basis of examination a and manner stated.	and/or inv	estigation, in my op	pinion, death occurr	red at the time, date	se(s) and manner a e and place, and du I. Date signed (Mon.	e to the cause(s)
			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)	001126	6	Aug 26	05
jH	-/ <i>O</i> Sta	_	31. Date filed (Month, Day, Year) AUG 29 2005 32. Resistrar's Signature &	L.	660 X	onumber UO1126 Levthorn	Av	Hager	skipu be

Physic	0.0	Decedent's Name (First, Middle, L.	_ast)							2. Date of De	ath Day	Year	3. Time of Death
/Medi		Ella L.	Harris							Hugust	- 19	2005	9:55A M
Exami	ier	4a. Facility Name (If not institution, g					_	Location of	of Death	,		ounty of Death	
		Doctors Commun					nham	If I lades	04 Uso			ince Ge	
uneral			Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. I	la <i>st birthd</i> ay) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	Cou	place (State or Foreign
irector		Usual Residence of Decedent						,		02/10/	L920	NOTE	h Carolina
M TI		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside City Limits
natural', or Itame 23a or 28a-f ebow Jisal Examiliar must be notified at	ţo	MD Prince	George's	Hy	attsvi	1116							1X Yes 2 □ No
7.28a	Director	10e. Street and Number	000180 5	11.7	uccov)	10f. Zip	Code				10g. Citize	n of What Cou	ntry?
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dica	ete	15. Decedent's (Specify only highest g			(Give	dent's Usua kind of wo	rk done c	during mos	t of work	ıng	16b. Kind	of Business/In	ndustry
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event, the M		17. Father's Name (First, Middle, La.		yrs.	Prac	tical	. Nu	18. Mothe	ar's Name	e (First, Middle			Center
	Be	Alex Parker	31)							Boone	, maiddir G	211121110)	
matic	5	19a. Informant's Name/Relationship	(Tuno Print)		10h Maili	na Address	(Street				er City or 1	Town, State, Zij	n Codel
traum		Sophia P. Smith									-	d. 2078	
other traumatic	1	20a. Method of Disposition	7 515001	20b. P	lace of Dispo	osition (Nar	ne of			Date		ation - City or T	
5		1 ☑ Burial 2 ☐ Cremation 3		State	emetery, cre					. 05			
injury e		4 ☐ Donation 5 ☐ Other (Special Service Lice)		Ma:	ryland				08-26			el, Mar eral Ho	
any injury once.		21. Signature of Vertex and Convice 210	0 00									D.C. 2	
7. 3.		23a P. f. Ever the disease or co	mplications that c	aused the death							_	D. 0. 2	Approximate
	23a. P. ft. B. or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a state, or heart failure. List only one cause on each line. Immediate Cause (Final												Interval Between
cian	11.0	discours or condition			1/	1 1	1	I	•				Onset and Death
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar 29355 Reg. NZ 005 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 2005 12:50 PM August 18. ALFRED LEVON JACKSON /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's County Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6. Sex **Funeral** XX M 2 F 12, 1932 SOUTH CAROLINA Director NOV. 577 42 1408 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County th and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Madical Examinar must be notified at XX□Yes 2□No Director MARYLAND PRINCE GEORGES UPPER MARLBORO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 11002 WHITE HOUSE ROAD 20774 Completed by Funeral filed within 72 hours after deeth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. ☐Yes XX No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX☐ No Specify: Specify: BLACK XX Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH CONTRACT HAULER SELF-EMPLOYED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be ၉ ODESSA JAMES A.B. JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If item 27 le m any injury or other treum once. DISTRICT HEIGHTS, MD 20747 8309 LAURA LANE TYRA JACKSON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 8/26/05 SUITLAND, MD MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 21. Signature of Funeral Service Licenses lares 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death a Athenselentie Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit or Attending Physicien: The law requires that the deeth certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown cete hes been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No certificete 1X Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 🛛 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XXves 2 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director; / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number August 19, 2005 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OGAR 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature_ State Registrar AUG 2 4 2005

State of Maryland / Department of Health and Mental Hygiene 200529356 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** MARIE 1.00 P JONES Av Co 21 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ounty General Hospital (Howard Year If Under 24 Howard If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 🖫 F 62 Yrs 190-36-1522 1943 Virginia Director August Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10b. Counts 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD Prince George's Landover 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 7630 ALLENDALE CIRCLE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Specify à 3 ☐ Widowed 4 X Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th CROSSING GUARD GOVERNMENT if Heelth and Mental Hygi Item 27 Is marked other other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Pages 1 and 2 should be fill timent of Heelth and Mental Hitem 27 le marked oth jury or other traumatic even Be ပ WILLIE SMITH DOROTHY SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JAMES JONES/SON 13303 STONE JUG LANE LAUREL, MARYLAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If eny Injury or once. 8/26/05 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 21. Signature of Fameral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME ha 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final / disease or condition resulting in death) SEPS15 **Physician** NAYS /Medical Examiner STAGERENAL DISEASE MONTHS END if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CEREBROVASCULAR ACCIDENT Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 1NO of Vital Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ N filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural To the Hospital or Attendi within 24 hours after death. To the Funerel Director; A 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Carifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) uphe MD AVG ZISTZOOS D0053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 SANTIAGO RO SUIME 110 COLUMBIA SHALLUNNALA COUP G 2 5 2005 32. Registrar's Signal State AUG Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 29 Margaret Gertrude Jameson 2005 11:32 P. Aug /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Yrs Dec 4, 1926 Director Maryland 220-20-8758 Usual Residence of Decedent with the Maryland r 28a-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number al Hygiene. | other than "natural", or items 23a or | other than "natural", er items or west bar. 22295 Gore Street 20650 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23, arry or other traumatic event, is Medical Examine must any or other traumatic event, is Medical Examine must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 ₹ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give TY Year or Dates: Specify: White Completed by 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha Pilkerton 2 Henry Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Josephine Curry/Daughter 22295 Gore Street, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Maryland Veteran Cemetery Sep 6, 2005 Cheltenham, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lineses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as consider or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between On and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the a d be detached f Ö 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital After this certification funeral director, Be 25. Was case referred to medi >1 examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 # No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Ratural 5 Pending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Carifying Phymician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 23a Cartifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) E 30. Name and address apperson who completed e of death (Item 23a) (Type, Print) 6 24035 Three Notch Road, Hollywood, Maryland Dr. J. Patrigk Jarboe, M.D. 31. Date filed (Month, Day, Year) 32. Registra Signature State 1 2005 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12/12/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 11:15A M 28 2005 August Mary Ann Jenneke
4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Somerford Place 10114 Sharpsburg Pike Social Security Number 6. Sex 7. Age (In yrs. last birthday) Washington County Hagerstown
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov 14 1922 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F 82 Director Wisconsin 351-12-Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examiner must be righted at 1 ☐ Yes 2 No Hagerstown Maryland Washington Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 19722 Spring Creek Road 21742 by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) illed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Maryland 21215-0036 Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental t Olga Zack Livingston Burton L. Livingston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eden Drive Hagerstown Maryland 21742 Karen L. Jenneke (daughter) 13911 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō Aug 30 2005 Smithsburg Maryland Department of Important: If any injury or once. Smithsburg Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Flin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 wk Cerebral Vascular Accident /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Dementia, Hyperparathyroidism Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 0 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: / 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a

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completely filled i 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/29/05 Mary E.M. D23815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41.10+1 Mary E. 354 Mill St. Hagerstown Maryland 21740

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Money MD

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31. Date filed (Month Day)

			1 - For State Registrer	State	of Maryla		artment of H		nd Mental Hy	giene 0 0	5 2935	9
П	Physicia	an	1. Decedent's Name (First, Midd	lle, Last)					2. Date of Dea		3. Time of Death	
	/Medic		Yun		Kwo	n				18, 200	5 12:30p	М
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Maryland	2 should be n and Mental is marked or raumatic ev	2	Unobtainable 19a. Informant's Name/Relation	ship (Type, Print)		19b. Mail	ng Address (Street		obtainable or Rural Route Numbe		State, Zip Code)	
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ē,	of Head		20a. Method of Disposition		I .	. Place of Disp	osition (Name of matory or other place		Date		City or Town, State	
E	Page in: #		* Burial 2 ☐ Cremation * 4 ☐ Donation 5 ☐ Other (•			/22/2005	Davidsor	wille,Maryla	nd
Baltimore,	permit. Pages 1 Department of H Important: if Ite any injury or ot once.		21. Signature of Funeral Service	cen ee		2	2. Name and Addres	ss of Facility	Hines Rina	ldi Fune	eral Home	ш
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	To the Hosl within 24 ho To the Func completely f	Med	29b. Signature and title of derti				29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
	7/		▶ Ilthelle	MD				D61007		August	18, 2005	
г	,		30. Name and address of perso	n who completed	cause of death (I	Item 23a) (Type				-0-0-		
			Kenneth Khan	dagle. M	D. 83	1 East 1	Iniversit	v Blvd	#25 Silve	r Snrino	MD 20903	
	Sta Registi		31. Date filed (Month, Day, Yea AUG 24		2 Registrar's Si			,	as otte	- obsesse	, 110 2000	

DHMH 17 Rev 1/2001

			State of Maryland / State Registrer	Department of Hea Certificate of De	ilth and Mental eath	Hygiene 2 (005 29360
	Physicia		1. Decedent's Name (First, Middle, Last) Esther Kaplan			of Death th Day 1St 21, 20	3. Time of Death 12:55A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey House	4b. City, Town, or Loc Rockvil			nty of Death
	Funeral Director		5. Social Security Number 577-36-5656 6. Sex 1 M 2 ▼ F 77		Under 24 Hrs. 8. Date (Mor	of Birth th, Day, Year) 19, 192	9. Birthplace (State or Foreign Country) Washington, DC
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To Maryland Montgomery Olne	wn or Location			10d. Inside City Limits 1 ★Yes 2 No
	h with the 23e or 28a ist be noti	al Director	10e. Street and Number 4221 Sandcastle Lane	10f. Zip Code 2083	32		of What Country? States of America
036	be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "neturet", or Items 23e or 28e-f show event, the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:		nic Origin? (Specify Yes Mexican, Puerto Rican, e Specify:		lace - American Indian, Ilack, White, etc. cify: White
Maryland 21215-0036	within 72 ho ene. than "netur ne wedical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ia. Decedent's Usual Occupetion (Give kind of work done durin life. DO NOT use retired)	n ng most of working		Business/Industry
land 2	e filed Il Hygi other vent, L	To Be Co	12 17. Father's Name (First, Middle, Last) Meyer Mehlman	Secretary 18.	. Mother's Name (First, I	Middle, Maiden Sum	ame)
, Mary	and 2 should be ralth and Mental 27 is marked our treumatic ev	-	19a. Informant's Name/Relationship (Type, Print) Rita Peskowitz - Daughter	9b. Mailing Address (Street and A	Number or Rural Route	Number, City or Tow	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic or once.		`4 □Donation 5 □Other (Specify) Mt.	of Disposition (Name of tery, crematory or other place) Lebanon Cemeter		5 Adel	n - City or Town, State
Ball	Departi Depart Impor any in		21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. D	Ballzansky sco	lle Pike, Ro	ockville,	
	Physician /Medical		23a. Pard Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Advanced Non-Herotographic pure to (or as a consequence of the condition of the	odgkins Lymphon			Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, Isacing to immediate cause. Enter Underlying Cause (Disease or injury				
8760,	icate be executed physicien and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of the consequence of t	e of):			
.O. Box 68	The law requires that the death certificate be executed tate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)			Date of delivery Month Day Year
0_	w requires that to be the signed by should be detailed.	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in	n Part I. 23e	. Did tobacco use co	ontribute to the cause of death?
Il Records,		Completed				. Was an autopsy performed? Yes 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/6	Other	6. Place of Death (Check 4 ☐ Nursing Home 5 ☐		Other (Specify) Userias
ion of	ath. er: After this ne funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	o. Time of 28c. Injury at Work?		scribe how injury occ	HOSPICE
Division	To the Hospitel or Attending Pt within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		City	or Town, State)	mber or Rural Route Number,
	the Hospi hin 24 hou the Funer npletely fill	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowled to the basis of examination and manner stated.	Ige, death occurred at the time, cand/or investigation, in my opinion			manner as stated. e, and due to the cause(s) ned (Month, Day, Year)
)	W With		29b. Signature and title of certifier	- 04	11218	8/	21/05
	٦			uncaster Mill R	Rd, Rockvill	Le, MD 208	355
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 4 2005 32 Registrar's Signature	Aparle			

State of Maryland / Department of Health and Mental Hygien 2005 1- Millend Items# 20 a,b,c per FH G851cel+16da06 6CDeath 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Month Albert Lindsey 10.55 AM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Lanham Doctors Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

April 28,1905 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 578-48-8561 1XM 2□ F Yrs. Director Virginia 100 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other treumatic event, the Mudical Examiner niver be notified at Prince Georges 1 Yes 2 □ No Md. Hyattsville Director 10e. Street and Number 10f. Zip Code 20784 10g. Citizen of What Country? 3909 71st Ave. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. "natural", or Items 11. Marital Status 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black 3 →Widowed 4 □ Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other treumatic event Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hotel 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucy Banks Phillip Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7614 Oxman Rd. Landover, Md. Rev. Mary Benbow/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition
1 □ Burial 2 ★ Cremation 3 □ Removal from State 20c. Location - City or Town, State Riverdale Crematory, 11-17-05 Riverdale, MD Wash.D.C. ` 4 ☐ Donation 5 ☐ Other (Specify) புறிட் 21. Signature of Fyreral Service License 22. Name and Address of Facility 20011 Wash., D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or height failure. List only one cause on each line. Latney's Funeral Home, Inc. 3831 Ga. Ave. N.W. Approximate Interval Between Onset and Death Immediate Cause (Final MALIGNANT ARNYTHMA Priysician CARDIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EMENTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760 nding physiclan Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ Nor 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 No Division of Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu after death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7305 A HANDUER PARENAY GREENBELT, MD 20770 ECIL 6EUNGE Registrar's Signature 31. Date filed (Month Day, Year) AUG 2 5 2005 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death For State Registrar 29362 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Dolly 25, Butler Logan 2005 August 2:15 a.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2₩F Yrs. Director 83 212-14-9995 Dec. 13,1921 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahow the Medical Examiner must be notified at Director 1 Yes 2 No St. Mary's Maryland Lexington Park 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19071 Three Notch Road 20653 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 10. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: Specify: Black ρ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed.
Department of health and Mental Hygis Important: if item 27 is marked any injury or other town. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Mitchell Butler Elizabeth Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isimae Bryan / Cousin 19071 Three Notch Road, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdns 8-29-2005 Leonardtown, Maryland 21. Signal of Eneral Solvice Licensed 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. B M00052 22955 Hollywood koad, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that interest appears) Examiner Due to (or as a consequence of): physician and is the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Hinknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes m 1 ☐ Yes 2 XNo 3 Probably 4 Unknown been si 24a. Was an autopsy performed? has Oiscare 4 acio reflex orscare besita SE 1_ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 KER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification; After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29/05 D51738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kae T. Aung, M.D., 24435 Mervell Dean Road, Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) 32. Registr State AUG 3 1 2005 > Registrar

			1 - For State Registrar	State of Ma	aryland / D	epa <i>Cer</i>	irtment of Hetificate of L	eaith and Death	d Ment	al Hygi	ene20	05	29363
	Div i . i		1. Decedent's Name (First, Middle, Last							ate of Death		Year	3. Time of Death
	Physici /Medio		INA MAE LANGD	ON						SUST 2	22, 200!		2:30 AM ^M
	Examin	er	4a. Facility Name (If not institution, give SUMMERVILLE @ WEST	· ·			4b. City, Town, or WESTM		eath		4c. County CARI	of Death ROLL	
	Funeral Director		5. Social Security Number 6. Se 213–16–1592	x □ M X □ F 7. Aga	e (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours N		ate of Birth fonth, Day, Y 15,	^{Ygar} 1920	9. Birthp <i>Co</i> ur VI	place (State or Foreign ntry) RGINIA
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Loc	cation					1	10d. Inside City Limits
	Maryla 1 sho	ō	MARYLAND CARROLL	ı	WESTM								1 ☐ Yes 27€No
	r 28a	rect	10e. Street and Number	***************************************			10f. Zip Code			10	g. Citizen of W	Vhat Cour	ntry?
	th with	Funeral Director	724 WINCHESTER DRI	VE			2115	7			UNITED	STA'	TES
	r dea	ner	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	panic Origin? , Mexican, Pu	(Specify) Jerto Rican	es or No-		e - Americ k, White,	can Indian,
36	s afte	by Fu	1 ☐ Never Married 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X 1 If Yes, Give Year or Dates:	10	1	☐Yes 2☐xNo	Specify:			Specify		ITE
9	filed within 72 hours after death with the Maryland Hygiene. thar then "natural", or flams 23a or 28a-1 show int, the Medical Examinar must be motified at	ed k	15. Decedent's Edu	cation	16a.	Deced	ent's Usual Occupa	tion		1	6b. Kind of Bu		
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	ed will ygien tar th	Con		4			TEACHER					CATI	NC
Maryland	uld be fil Aental H rked oth tic evan	To Be	17. Father's Name (First, Middle, Last) SAMUEL RAKES							t, Middle, M BURGE	aiden Sumam ESS	е)	
_	and 2 sho alth and h 127 is ma er trauma		19a. Informant's Name/Relationship (7) JAMES R. LANGDON,				g Address (Street a						Code) 21157
Baltimore,	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition M□ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		cemeter	y, crem	sition (Name of patory or other place EK CEMETE	XY 8,	Date /25/20		0c. Location - (own, State ARYLAND
Balt	parmit. Departnimports any inju		21. Signature of Funeral Service Licens	alast !	MIBLO	MYI	Name and Address	RAW FUN	VERAL	HOME,	P.A.		
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caudd	the death. Do n	ot ente	WILLIS Ser the mode of dying	such as card	diac or resp	iratory arres	ER, MD		1157 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Attrolo	o sale	Ne	Hic Ca	rdio	Hers	rula	1 dus	lase	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):	0	- 1 la	Λ	Oa a	10.	-11	100
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a contequence of	of):	Cerewa	U Da	me	la)	Tell	Leu	T 3 year
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.	`								
,00	icate be executed physician and s the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequence o	of):							
68760		edical		d									
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date Mon		ery Day Year
	that the	y Ph	Part II. Other significant conditions col	ntributing to death bu	at not resulting in	the un	derlying cause giver	ı in Part I.	2	3e. Did toba	acco use contri	bute to th	ne cause of death?
ords	w requires been sign should be	ted by							-	1 🗌 Yes	2 12 No	3 🗌 Prob	ably 4 □Unknown
Vital Records,	yaician: The law I is certificate has bi director, page 2 sh	Completed							-	4a. Was an autopsy performe	24b. W	/ere autor rior to con eath? □ Yes	psy findings available inpletion of cause of
=	Attending Phyaician: Th r death. ector: After this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Out		Other	26. Place of D			1/		- No 17 7
o		1-11	27. Manner of Death	28a. Date of Injur	y. 28b. Ti	ime of	3 DOA 28c. Injury Work	# [] Nutsini			v injury occurre	r <i>(Specif</i> y ed	LIVING
joi	Attending I death. ctor: After y the funer	atlo	1 Matural 5 Pending 2 Accident investigation	(Month, Day	rear) in	ijury		es 2□No					,
Division of	Hospital or Attens 24 hours after deatl Funaral Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, far :. (Specify)	m, stre	et, factory, office			ocation (Stre ity or Town,		er or Aura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and	death Vor inv	occurred at the time estigation, in my opi	e, date and pla nion, death oc	ace, and du courred at t	e to the cau he time, dat	use(s) and man e and place, a	ner as stand due to	ated. the cause(s)
	To the total	ž	29b. Signature and title of ce tilie	J HI			29c. License	number		290	d. Date signed	(Month, L	Day, Year)
	10/52		France	7	ر 		1)38	417			8 23	10)
	V0-5		30. Name and address of person who co		eath (Item 23a) (I NER AVEN			WESTM	INSTE	R, MD	2115	57	
,	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 4 2		r's Signature		/						
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State of Maryland / Department of Health and Mental Hygiene 005

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			1 - Stete Registrar			Ce	rtificate	e of L	Death			Reg. No	2005	2936) 4
	Dhysisi		1. Decedent's Name (First, Middle							2	. Date of De	ath		3. Time of Dea	ath
	Physici /Medio		Elsie I	eopold.						Αι	1gust	19,	^y 2005 Year	11:45P	М
	Examir		4a. Facility Name (If not institution	, give street and number	r)		4b. City, T	Town, or	Location o	f Death		4c.	County of Death		
			Shady Grove Ac					kvi]					Montgomer		
r	Funeral Director		5. Social Security Number 129–18–8258	6. Sex 7. A	Age (In yrs. las	t birthday) Yrs.		Days	Hours 1	Min.	Date of Birt (Month, Da	y, Year)	9. Birthr	place (State or Fo	reign
			Usual Residence of Decedent	X	95					Ju	11y 3,	_191	.0 New Y	ork	
	yland Now		10a. State 10b. County		10c. City, 7	Town or Lo	cation						1	0d. Inside City Li	imits
	Man art sh	Į.	Maryland Montg	omery	Roc	kvill	.e							1X Yes 2] No
	h the	lec	10e. Street and Number				10f. Zip (Code				10g. Cit	izen of What Cour	ntry?	
	th wit	Funeral Director	ll Kirkfield Cou	ırt			208	50				U	J. S. A.		
	ems ems	ner	11. Marital Status	12. Was Deceden		13.	Was Decede	ent of His	spanic Orig	in? (Specif	y Yes or No- an, etc.)	-	14. Race - Americ Black, White,		
36	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show the Medical Evantiner must be redified at		1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes 2 € If Yes, Give	No		1□ Yes 2			, ,	, 0.0.,			ite	
Ö	hour tural	d b		Year or Dates								151 14			
15	In 72 nair	lete	15. Deceden (Specify only highes	t grade completed)		(Give	dent's Usual kind of work DO NOT use	done d	tion uring most	of working		16b. K	ind of Business/In	dustry	
21215-0036	with lene r than	Completed by	Elementary/Secondary (0-12) 12 Years	Colfege (1-4or	r 5+)	-	etary				1	Fi	llm Indus	stry	
פַ	filed I Hyg other	a)	17. Father's Name (First, Middle,	Last)					18. Mother	r's Name (F	irst, Middle,	Maiden	Sumame)		
<u>la</u>	uld be Menta rked tic ev	To B	Rudolph Gerr	sheimer					Ma	arie I	Bande1	WO			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Evalut art must be indiffical at once.		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address ((Street a	nd Number	r or Rural R	loute Numbe	r, City o	r Town, State, Zip	Code)	_
Σ	and 2 saith n 27 i		Doris R. Berk -	- Daughter		11 Ki	lrkfie	1d (Court	, Rocl	kville	, Ma	aryland 2	0850	
Baltimore,	of He		20a. Method of Disposition 1∑ Burial 2☐Cremation	3 THE amount from State		e of Dispo etery, crer	sition (Name	e of her place	9)	Date		20c. Lc	ocation - City or To	wn, State	
Ĕ	Pag ment		`4 □ Donation 5 □ Other (S)	pecify)	New	Mont	efior	e	8,	/22/20	005	Pine	elawn, L.	I., N.	Υ.
Salt	epartit.		21. Signature of Funeral Service	icensee		22 F.0	. Name and	Addres:	s of Facility	neral	Direc	tion	n, Inc. e, Maryla		
_	0 0 E € 0		Monald (Motil	emyl		91 Ro	ckvi	111e 1	Pike,	Rockv	ille	e, Maryla	ind 208.	52
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. I	Do not ent	er the mode	of dying	, such as o	cardiac or re	spiratory ar	rest,		Approximate Interval Between	1
	Physician		fmmediate Cause (Final disease or condition resulting in death)	aUrina	ary Tra	ct I	nfecti	on						Onset and Deat	a
Н	/Medical Examiner		resulting in death)	Due to (or a	s a consequen	ce of):									
Ь		-	Sequentially list conditions,	b. Acute	e Chron	ic Re	enal F	ailu	ıre						
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,	- 1-								
	and and al-tra	xar	that initiated events resulting in death) Last		volemic s a consequen		ck .								
260	siclar siclar														
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical		0.											
XO	0 2 4		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy		· ·					. 12	23d. Date of delive	ry	
m m	deati e atte	lcla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant a	2 ∏Fetal de at time of death		Ectopic pred Other <i>(spe</i>							Day Year	
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Ś	es this gned be de	by F	Part II. Other significant condition	ns contributing to death	but not resultin	g in the ur	nderlying cau	use give	n in Part I.		23e. Did to	bacco u	se contribute to th	e cause of death	?
ord	w requir been si should										1 🗆 Y	es 2[□No 3□ Prob	ably 4 X Unkno	nwc
ecc	e law r has be je 2 sh	ple									24a. Was a		24b. Were autop	sy findings avail	able
<u> </u>	The la	Completed	A Jan								perfor	med? 2 🖾 No	death?		UI
/ita	ysiclan: Th is certificate director, pag	Be (25. Was case referred to medical examiner?						26. Place o	of Death (C	heck only or				
7	Physic this or al dire	P	1 ☐ Yes 2 💢 No	Hospital: 1 🔀 Inpati	· · · · ·	Outpatien			4 NOI3	sing Home	5 🗌 Resid	ence 6	S □Other (Specify)	
Division of Vital Record	Attending Physiclan: r death. sctor: After this certifice by the funeral director.	Certification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year) 28	b. Time of Injury		c, fnjury Work			Describe h	ow infun	y occurred		
<u>s</u>	tend leath tor: / the fi	catl	2 Accident investig	ation of he			M		es 2 🗆 N						
\leq	or Attendate deat	ertif	4 Homicide determi	ned 286. Place of in	ijury - At home itc. <i>(Specify)</i>	, farm, stre	eet, factory,	office		28f.	Location (S City or Tow		d Number or Rura)	Route Number,	
	spital or Atten ours after deat lerel Director: filled in by the	Co	29a. Certifier 1 ☑ Certifying	Physician: To the best	t of my knowled	des dosth		Alella Maria							
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the f	edical	(Check only 2 Medicel E	Physicien: To the best examiner: On the basis of and manner s	of examination	and/or inv	estigation, i	t the time n my opi	nion, death	place, and occurred a	due to the c at the time, c	ause(s) late and	and manner as sta place, and due to	ated. the cause(s)	
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	4.5	tatoa.		29c.	License	number		2	9d. Date	e signed (Month, L	Day, Year)	
	F \$ F 0		Samo	- Kho	VVO	4	_]	D005	8965				st 20, 2		
	V		30. Name and address of person v	who completed cause of	death (ftem 23	a) Type I	Print)								
			Saima Khawaja		11119	Rock	ville	Pik	e, Su	iite l	00, R	ockv	ille, Ma	ryland 20852	
	Sta		31. Date filed (Month, Day, Year)	32 Regist	rar's Signature	1	MD -				-				
4	Registr	ar	AUG 24	ZUUD KORA	r K	Sep.	Was !								

			For Stata Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F	lealth and I Death		jiene _{eg. No} 2 (005	29365
	Physici	an	Decedent's Name (First, Middle					2. Date of Dea Month	th Day	Yeer	3. Time of Death
	/Medio		Rosa 4a. Facility Name (If not institution	A. Martin , give street and numb		4b. City, Town, or	Location of Death	08	21 4c. Cour	05 nty of Death	1:05 A M
	L Adilli.	•	Holy Cross Ho	spital			Spring		Mon	ntgome	ry
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	, Year)	Сош	place (State or Foreign ntry)
	Director		217-96-3662 Usual Residence of Decedent		93 Yrs.			04 20) 12	Nica	ragua
	nyland how		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Ba-f s	cto		gomery	Silver S	*					1½ Yes 2 □ No
	s or 2	Funeral Director	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·		10f. Zip Code		1	0g. Citizen o	of What Cour	ntry?
	death ms 23	nera	1401 Oakview I	12. Was Deced		20903 Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	USA 14. R	ace - Americ	ean Indian.
9	or ite	Fur	1 ★Never Married 2 Marri	Armed Force ied 1 Tes 2 If Yes, Give	TVN0	If Yes, specify Cuba 1 ☑ Yes 2 ☐ No				lack, White.	
93	hours urai',	d by	3 Widowed 4 Divorced	Year or Date	es:					cify: HIsp	
-5	within 72 hours after death with the Maryland ene. than "natural; or items 23s or 28a-f show ta Madisal Esa niter mast be nuffied at	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	dent's Usual Occup kind of work done of DO NDT use retired	during most of wor	king	16b. Kind of	Business/In	dustry
212	d with giene	mo:	Elementary/Secondary (0-12) 6th.	College (1-4		omemaker			Pri	vate	
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, I	Last)			18. Mother's Nan	ne (First, Middle, I	Maiden Sum	ame)	
Z	hould d Men narke natic	ဥ	Jose Tomas Cas 19a. Informant's Name/Relationsh		10h Maiti	an Address (Chana)		Martine			
Z	ith an 27 is r		Maria Martine			ng Address (Street					
re,	s 1 ar		20a. Method of Disposition		20b. Place of Dispo	Oakview position (Name of	prive, s		20c. Location		
Ë	Page nent c ant: If ury or		1 ☑Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp		General (1	31-05	Managu	ıa, Ni	caragua
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural; or items 23a or 28a-f show emportant: If item 27 Is marked other than "natural; or items 23a or 28a-f show only injury or other traumatic event, Ite Medical East infer fourt the notified at once.		21. Signature of Funeral Service I	Licensee		2. Name and Address 217 9th.					
	P		23a. Part . Enter the disease, or shock, or heart failure. List	complications that cau only one cause on eac	sed the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate Interval Between
E	Physician	e a	Immediate Cause (Final disease or condition resulting in death)	a Cong	estive Heart	Failure					Onset and Death
	/Medical Examiner		resulting in deathy	Due to (or	as a consequence of):						
	1961	Jer	Sequentially fist conditions, if any, leading to immediate	b. — Due to (or	as a consequence of):						
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or	as a consequence of):						
687	icate l physics the t	edical		d.					_		
Box (n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		7-			23d. D	ate of delive	ry
	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death 5[Ectopic pregnancy Other (specify)					Day Year
0	that the led by t detach	Phy	9 ☐ Unknown Part II. Other significant conditio			ndarhina cauca anu	on in Part I	23a Did toh	2000 HEQ 00	atributa to th	e cause of death?
Vital Records,	The law requires that the death certificate be executed tile has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ed by	Renal Failu								ably 42(Unknown
ecc	e law re has be je 2 sho	ompieted						24a. Was ar	n 24b	. Were autor	osy findings available inpletion of cause of
<u>e</u>		Соп						perform 1 Tes 2	1 0 0? [death? 1 🗌 Yes	
Vita Sita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:		Othe	Are.	th (Check only on			
o	ig Physter this	-	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of	Injury 28b. Time o	28c. Injury	at	ome 5 Reside 28d. Describe ho			")
ion	Attending I r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	Day Year) Injury	Work	:? /es 2 □ No				
Division of		ertification:	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place of	Injury - At home, farm, str , etc. (Specify)	eet, factory, office		28f. Location (Str. City or Town		nber or Rura	Route Number,
	Hospital or Attendir 14 hours after death. Funeral Director: Af tely filled in by the fur	OL	29a. Certifier 1 ★ Certifying	g Physician: To the he	est of my knowledge, deat	Occurred at the time	e date and place	and due to the co	use(c) and -	nanner oo ch	ated
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edicai	(Check only 2 Medical E	Examiner: On the basi and manner	s of examination and/or in	vestigation, in my op	pinion, death occur	red at the time, da	ite and place	, and due to	the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	, 1:	11 4-	29c. License		29	d. Date sign	ed (Month, L	Day, Year)
^			I hilly	w you	SIN	D2230	9	A	ugust	23, 20	005
R	(3)		30. Name and address of person v								
	Sta	te	Philip W. Potl	ATC Dog	3 Flower Ave		er Sprin	g, MD. 20	0901		
	Registr	¥ .	AUG 2 4 20	105 Block	istrar's Signature	W					

		Registrar	State of Maryla	ind / Depa <i>Cei</i>	artment of H rtificate of L	ealth and Death	R	eg. No.	05	29366
Physici /Medio			Hender				2. Date of Dear	Day 22	Yeer	3. Time of Death A
Examir Funeral	ier	4a. Facility Name (If not institution, give st. Carrol Hospita 5. Social Security Number 6. Sex.	l Center 7. Age (In yr	s. last birthday)	4b. City, Town, or WCS TO If Under 1 Year Months Days	Location of Deat N i O S + C If Under 24 Hrs Hours Min.	8. Date of Birth	Voarl	9. Birthpla	ace (State or Foreign
Director		219-20-0255 Usual Residence of Decedent 10a. State 10b. County	00	Yrs. City, Town or Lo	cation		May 28	, 1919	Mary.	I and Od. Inside City Limits
the Mary r 28a-f sh	Director	Maryland Carrol 10e. Street and Number	_1		10f. Zip Code	Hamps		0g. Citizen of V	Vhat Count	1 ☐ Yes 2 🖾 No
death with	Funeral D	1122 South Main St	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi	21074	Specify Yes or No-	14. Race	JSA - America	
ral', or Ita	þ	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Tes, specify Cuba 1 ☐ Yes 21⁄2 No	Specify:	to Rican, etc.)	Specify	k, White, e	white
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic evant, the Madical Examinational and other contractions.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired Homema	luring most of wo	rking	16b. Kind of Bu	Home	ustry
Vidina buld be file Mental Hy arkad othi	To Be (17. Father's Name (First, Middle, Last) Edgar Fishpaw				Ethe	me (First, Middle, M el Wisner			
Vic d 2 d 2 d b a 7 ls trau		19a. Informant's Name/Relationship (Type Janet M. Stailey,	daughter	1153	ng Address (Street a		Grabill,	IN 4674	41	
in in Pa		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	•	sition (Name of matory or other place d Cemeter	·	^{Date} 25/2005	20c. Location - Hampst		
parit. Departit. Departit. Imports any inji.		21. Signature of Fundal Service Licensee	Walin	e		n Main S	Eline Fur t, Hampst	cead, M		74
The law requires that the death certificate be executed The law requires that the death certificate be executed ate has been signed by the attending physician and multiple capage 2 should be detached for use as the burial-transit	dical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consc	equence of):	olon ca	neer				Interval Between Onset and Death
The death certification of the attending or the attending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 □	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliven	y Day Year
w requires that I	by	Part II. Other significant conditions conti	ributing to death but not re	esulting in the u	nderlying cause give	n in Part I.	23e. Did tob			e cause of death?
	Completed						24a. Was ar autops perform 1 Yes 2	y p ned? d	rior to comp eath?	sy findings available pletion of cause of
TOTATION OF THE HOSPITAL THE HOSPITAL OF THE HOSPITAL OF THE HOSPITAL OF THE HOSPITAL OF THE CONTROL OF THE HOSPITAL OF THE HO	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Minpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing H	ath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Othe		
To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor: After th completely filled in by the tuneral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (Str. City or Town		er or Rural i	Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 ★ Certifying Physical Cartifying cien: To the best of my ker: On the basis of examinand manner stated.	nowledge, death	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	e, and due to the ca urred at the time, da	use(s) and mar ate and place, a	nner as stat nd due to t	ted. the cause(s)	
To t withi To t	M	29b. Signature and title of certifier KWushaen	MD		29c. License	number 0 29 7 5		9d. Date signed 8 1 7 2 1		ay, Year)
PA		30. Name and address of person who con 295 Stener Ave	pleted cause of death (It			0 21157				
Sta Registi		31. Date filed (Month, Day, Year) AUG 2 4 ZUU	# 307 W 32. Registrar's Sig	nature	arte					

			1- State of Marylan		artment of Hertificate of L			ene . No.		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Faerie JoLane Manon				2. Date of Death Month August	22 2 0 22 2	005	3.2mpr 3 am
	Examir		4a. Facility Name (If not institution, give street and number) 1924 Winston Drive			stown		4c. County Washi		County
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. In the second security Number 162-46-4528 1 M 2X F 6	9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Dec 13	1935		lace (State or Foreign try) Sylvania
	h the Maryland or 286-1 show emotified at	Director	10a. State 10b. County 10c. City Maryland Washington 10e. Street and Number	, Town or Lo Hager	stown 10f. Zip Code		10g	. Citizen of V		0d. Inside City Limits 1 X Yes 2 □ No try?
900	72 hours after death with the Maryland Instural', or Items 23e or 28e-1 show digal Examiner mast be muffied at	by Funeral	503 Lynne Haven Drive Apt. 5 11. Marital Status X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.: Armed Forces? 1 Yes 2 Xivo f Yes, Give Year or Dates:	ŀ	2174 Vas Decedent of His Yes, specify Cuban □ Yes 2∑No			Blac	State e - America k, White, e	a <i>n</i> Indian, etc.
Maryland 21215-0036	l within iene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	ent's Usual Occupa kind of work done do DO NOT use retired) HOMEMAK	iring most of worki	ng I		al Re	sidence
laryland	should be and Mental s marked c sumatic eve	To Be	17. Father's Name (<i>First, Middle, Last</i>) Ralph B. Manon 19a. Informant's Name/Relationship (<i>Type, Print</i>)	19b. Mailin	g Address (Street ar	Mildre	e (First, Middle, Mai d L. Knep Il Route Number, C	per		Code)
Baltimore, N	Pages 1 and 2 nent of Heelth int: If item 27 I		1 反 Burial 2 ☐ Cremation 3 ☐ Removal from State	ace of Dispos metery, cren	Winston Sition (Name of patory or other place) Cemetery	1 [. Location -	City or Tow	
Balti	permit. Pages Department of I Importent: If it any injury or o		21. Signature of Funeral Service Licensee	22	Name and Address	of Facility Do rn Blvd.	uglas A. N. Hager	Fiery	Fueni Mary	•
	Physician / Medical Examiner the private ransit the private	Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) are consequenced.	ence of):	DMA F				1	Interval Between Onset and Death
.O. Box 68760,	death certifi e attending I id for use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mon	e of delivery	y Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resul	ting in the un	derlying cause given	in Part I.	23e. Did tobaci	1		cause of death?
Vital Records,	The law ate has b page 2 s	e Completed	25. Was case referred to medical			20 Plant (Part)		₽ pr	rior to comp eath?	sy findings available pletion of cause of
Division of Vi	g ×	Certification: To B	examiner? 1	R/Outpatient 28b. Time of Injury	3 ☐ DOA Other: 28c. Injury a Work?	4 🗀 Nursing Hon	,			
DİVİ	pite in		3 Suicide 4 Homicide 28e. Place of Injury - At hor building, etc. (Specify)				8f. Location (Street City or Town, Si	tate)		
	To the Hospitel within 24 hours a To the Funere! completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	on and/or inve	estigation, in my opir	ion, death occurre	d at the time, date	and place, ar Date signed	nd due to th	he cause(s)
)	d		30. Name and address of person who completed cause of death (Item :			55991	1 8	3/25	70	2
H	Sta Registr	-	31. Date filed (Month Day Year) 29 2005 32. Redistrar's Signature of the State of t	Ager 4. A.	stoun, N	D. 217	42			

			1 - For State Registrar	State o	f Marylan		artment of				giene Reg. No. 2	05	29368
	Physic		Decedent's Name (First, Middle, James Edison Ma							2. Oate of Dea Month	ath Day	Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution,		mber)		4b. City, Town,	or Location	of Death	Augus	4c. Count		#1:43
	Funeral		Shady Grove Adv 5. Social Security Number 219-46-8479	entist H Sex 1 DMM 2 DF	7. Age (In yrs. I	ast birthday) Yrs.	Rockvil If Under 1 Yea Months Day	r If Under	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Ye <i>ar)</i>	9. Birth	ery pplace (State or Foreign untry)
	Director		Usual Residence of Decedent 10a. State 10b. County		57	7. Town or Lo	cation			Aug. 13	3,1948		ryland
	the Maryl	Director	Maryland Montg	omery			mery Vil	lage	·		10g. Citizen of	What Co.	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with	a D	19301 Watkins	Mill Road	đ		2088	16			rog. Citizeri or	USA	and y ?
980	within 72 hours after death with the Maryland ane. then "naturel", or Items 23a or 28e-f show the Madical Exprinter must be notified at	by Funeral	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 √∑ No ⁄9	t	Vas Decedent of I Yes, specify Cu I ☐ Yes 2 No	ban, Mexicar	n, Puerto	cify Yes or No- Rican, etc.)	14. Ra Bta Speci	ce - Amer ick, White	ican Indian, , etc. White
1215-0036		Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		-4or 5+)	(Give life. L	lent's Usual Occu kind of work done OO NOT use retir	during mosi ed)			16b. Kind of E	- lusiness/li	ndustry
d 21	Hygie other	a	12 17. Father's Name (First, Middle, La	st)		Office	e Sales			tive (First, Middle,		les	
Maryland	ould be I Mental varked o	To B	William Ford M	24-5 T-1-1-1				Mar	y Br	ailsfor	d Brig	gs	
Mar	nd 2 sh lith and 27 is m r treum		19a. Informant's Name/Relationship Mary Jane Lacey				g Address <i>(Str</i> ee Queen M						
Baltimore,	Pages 1 a lent of Hea nt: If item	1 2	20a. Method of Disposition 1 Burial		! св	ace of Dispos	sition (Name of patory or other plants) Cremator	ace)	Augu	st 22	20c. Location	- City or T	own, State
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or pher treumatic evone.		21. Signature of Funeral Service Lic		2	Fi 50	Name and Addr Cancis J OO Unive	ess of Facility COII	ins	Funeral	Home	Inc	Virjinia , MD 20901
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that cally one cause on ea	aused the death. ach tine.	. Do not ente	or the mode of dy	ing, such as	cardiac o	respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical	Î	disease or condition resulting in death)	a Due to (cras a conseque	ence of):	79	Cry	Ru	re			Himites
	Examiner	ē	Sequentially list conditions,	b. Due to (Car &	in a cons		ary	e	>t			himites
	and transit	Examiner	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	Hear-	+ I	iseas	e	_				
68760,	icate be executed physician and s the burial-transit	edicai Ex	resulting in death) Last	Due to (CW01	NIC (Renal	Faile	uve	/			
P.O. Box 6	death certii e attending id tor use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live bi	come of pregnan rth 2 Fetal cant at time of dea wn	death 3 🗍	Ectopic pregnand Other (specify)	у				te of delive	ery Day Year
	es lgr	by	Part II. Other significant conditions	contributing to de	ath but not result	ting in the un	dertying cause gi	ven in Part I.			pacco use cont	nbute to th	he cause of death?
Division of Vital Records,	The ate h page	e Completed	05 W.								No S	Were auto prior to co death?	psy findings available mpletion of cause of
Ţ	Physicie this certi al directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{A} \)	Hospital: 1 🗆 Ir	patient 2	R/Outpatient	3□ DOA Ott			(Check only onle e 5 ☐ Reside		er (Specifi	iv)
sion o	ding After funer	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	on	f Injury 7, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	y at	28	3d. Describe ho			,,
DIV	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		4 Homicide determine	d 286. Place of buildin	of Injury - At horr g, etc. <i>(Specify)</i>					City or Town	, State)		l Route Number,
	te Hosp 124 hou 16 Fune detely fi	edical	29a. Certifier (Check only one) 1 Certifying F 2 Medical Exercises	hysicien: To the laminer: On the bar and mann	sis of examinatio	ledge, death on and/or inve	occurred at the tile estigation, in my o	ne, date and pinion, death	place, ar occurred	nd due to the ca d at the time, da	use(s) and ma ite and place, a	nner as st and due to	tated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	*			29c. Licens	e number	ı	,	d. Date signed		Day, Year)
•	2	-	30. Name and address of person who	completed	of dooth (hand	120) (75	6-	330	14		LUGUS		4, 2005
			POOPAK BAHK	TIARI, N	1.D. 99	OI ME	rint) DICAL CI	ENTER	- De	IVE, GA	ITHERS	BURG	, MD
	Stat Registra	-	31. Date filed (Month, Day, Year) AUG 24	2005	gistrar's Signatu	10 M	artie			•			,

			State of Maryland / Department of Health and Mental Hygiene 1- State of Maryland / Department of Health and Mental Hygiene 24a, per verb., G2/47/02/08/05/dhb. 1- State of Maryland / Department of Health and Mental Hygiene
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Anna Mae Miller 2. Date of Death Month Day Year Month Vear 4c. County of Death 4c. County of Death
	Funeral Director		WASHINGTON COUNTY HOSPITAL 5. Social Security Number 232-28-2729 1 M 2 K 82 Yrs. HAGERSTOWN WASHINGTON WASHINGTON WASHINGTON 9. Birthplace (State or Foreign Months) Days Hours Min. (Month, Day, Year) (Month, Day, Year) 12-06-192 CHARLESTON,
	h the Maryland r 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV JEFFERSON SHEPHERDSTOWN 1 □ Yes 2 □ No
	ath with the s 23a or 28	rai Director	10e. Street and Number 200 EAST NEW STREET 10f. Zip Code 25443 USA
9600	n 72 hours after death with the Maryland "netural", or items 23a or 28a-f show coffeel Expressed Trust be notified at	d by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1
21215-0036	d within 72 piene. r then "ne	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2 HOMEMAKER 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) When the complete of the complete o
Maryland	d 2 should be tiled th and Mental Hygid 7 is marked other treumetic event, II	To Be	17. Father's Name (First, Middle, Last) EDWARD JACKSON SPINKS 18. Mother's Name (First, Middle, Maiden Surname) LULA MAY BOXWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code)
	1 and 2 s Health ar em 27 is ther treu		CYTHNIA KELLER, DAUGHTER 205 N. DUKE STREET, SHEPHERDSTOWN, WV2544 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition) 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		***Conation 5 Other (Specify) WVU MEMORIAL VAULT08/18/06 MORGANTOWN, WV 21. Signature of Funeral Service Licensee WVU HGR, PO BOX 9131, MORGANTOWN, WV 2650
	Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
,8760,	J.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d
.O. Box 6	v requires that the death certitics been signed by the attending ph should be detached for use as th	Physician/Med	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Year Year
Records, P.	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown
Vital Rec	ien: The law rtificate has b ctor, page 2 s	Be Completed	Type now europe de la Competition de la Competit
Division of V	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Certification: To E	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify)
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Diractor: completely filled in by the	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)
	- s - ö		D 26 806 August 18, 2005
	Sta Registr	-	SEP 0 8 2005 31. Date filed (Month) Day, Year) 32. Registrar's Signature SEP 0 8 2005
DH	MH 17 Rev 1/20	001	ORIGINAL

Amend item#5, Perint of Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 0 0 5 1 - For Stata Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 305 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 10NTGOME Date of Birth (Month, Day, b 19, Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1□ M 2 F 64 Yrs Feb 1941 Kentućky Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Folcroft Lane 20774 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. ģ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hairstylist Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert E. McClain Elva Potter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keva L. Riddick / Daughter 1012 Folcroft Lane Upper Marlboro MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8-19-2005 Alexandria Va * 4 ☐ Donation 5 ☐ Other (Specify) Crematory
Name and Address of Facility Pope Funeral Home Signature of Funeral Service Licensee 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FROSCLE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 20 No 1 ☐ Yes 28 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1/ Yas 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records,

physician and s the burial-transit as use jo þ signed t page 2 s Jas certificate this After death. after death Diractor: in 24 hours the Funeral Dirac. þ within 24 ha To the Fund completely f

Funeral

Director

or 28a-f show

"natural", or itame 23a

Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If Itam 27 Is marked other than "natural", or Ital

permit. Pages 1 and 2.
Department of Health ar
Important: If Itam 27 Is
any injury or othar trau

Physician

Baltimore, Maryland 21215-0036

other traumatic event. Its Medical Examinar must be notified at

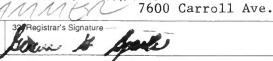
death with the Maryland

State Registrar

31. Date filed (Month, Day, Year) AUG 2 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

29d. Date signed (Month, Dav. Year)

Takoma Park, Maryland

			For State Registrar	State of Maryla	nd / Dep <i>Ce</i>	artment of H	ealth and N Death		ene2005	29372
	25		1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Richard		.11e			AUGUST	23, 2005	0030 M
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or Brunsw:	Location of Death		4c. County of Death Frederic	-1 _e
			610 Ninth Avenu 5. Social Security Number 6. Sex		s. last birthday,		LCK. If Under 24 Hrs.	8. Date of Birth	9. Birtho	place (State or Foreign
	Funeral Director			M 2□F 57	Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) Cour 1947 Mary	yland
	D	ļ	Usual Residence of Decedent							
	arylan ehow	_	10a. State 10b. County		City, Town or L				1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-1	Directo	Maryland Frederic	k	Teffers			100	. Citizen of What Cour	**
	with t		10e. Street and Number 3887 Shadywood Dri	W.A.		10f. Zip Code 21755		Tog	USA	iuy?
	72 hours after death with the Maryland "naturel; or Itema 23e or 28a-f ehow	Funeral		2. Was Decedent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Americ	
0	or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give		If Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black, White,	
9500-512	ral', c	d by	3 ☐ Widowed 4 X Divorced	Year or Dates: 66 -	- 69	1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	nite
ק	within 72 ho jene. r than "natur it o yeolon	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of wor	rking 16	b. Kind of Business/In	dustry
	withly ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		Design Te	•	n E1	ectric Pow	er Company
2	fileo the int,	e Co	17. Father's Name (First, Middle, Last)		Dodd	505282		ne (First, Middle, Ma		
Maryland 2	e d ta	To B	Ralph Browning	Naille			Kathle	een Virgi	nia Bussa	ırd
a S	de la la la la la la la la la la la la la	-	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mail	ng Address (Street	and Number or Ru	ıral Route Number, C	City or Town, State, Zip	Code)
	and 2 lealth a m 27 ls		Kathleen B. Naille	e / mother	3887	Shadywood	d Drive,		, Maryland	1 21755
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, cre	osition (Name of matory or other place		100	c. Location - City or To	
Ĕ	Part ury		* 4 □ Donation 5 □ Other (Specify)	St	. Paul'	s Luthera	in 8–26	-	ersville,	
Ball	permit. Pag Department Important: eny injury o		21. Signature of Frineral Service Vice ise	· /-		2. Name and Addres			ain Street	
	2079 a		23a. Part1. Enjer the disease of complic	un					ville, MD	Approximate
	/Medical Examiner	Examiner	shock, ortheart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		equence of):	ROTIC	CHRIC	VASCULA	R DISEASE	Interval Between Onset and Death TEMPS
O. Box 68760	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 D No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of delivi	ery Day Year
ds, P.	uires that the de signed by the a ld be detached f	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to to	
Vital Records,	Physician: The law requires that the rthis certificate has been signed by th rail director, page 2 should be detach	Completed						24a. Was an autopsy performs	prior to co death?	opsy findings available impletion of cause of
<u> </u>	cian: ertific	Be	25. Was case referred to medical examiner?	a said la		Osto		ath (Check only one)		
1	shysi this c	P_O	Yes 2 No	100000000000000000000000000000000000000	☐ ER/Outpatie		4 Nursing F	lome 5 Residen		_
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the funeral director,	Certification;	1 Satural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injury	M 1				lot
N	ital or Att		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)			City or Town,		
	he Hosp in 24 hou he Funer pletely fill	Medical		ician: To the best of my k ier: On the basis of exami and manner stated.				urred at the time, date	e and place, and due to	o the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	llas,	M.D.	29c. Licens	e number 16675		Date signed (Month,	Day, Year) 23, 2005
١	2		30. Name and address of person who co	mpleted Luse of death (II	tem 23a) Type	Print) WNSULC	5 P	10 21-	116	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2 4	32. Regis fr's Sig	nature &	South South	,			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day **Physician** August 18, 2005 02:44 a M Beatrice Osbia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George Malcolm Grow Hospital Camp Springs If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Days New York June 19,1917 88 579-16-7675 Director Usual Residence of Decedent Pages 1 and 2 should be illed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: if Item 27 le marked other then "netural", or Items 23e or 28e-f ehow ary or other treumatic event, if a Medical Examinal must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1X Yes 2 □ No Completed by Funeral Director DC: Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 444 Ridge Road SE 20019 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Statistical Specialist Federal Government 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown Houston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Helen Moss / Daughter 1615 Owens Road Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/23/05 Alexandria, Virginia Metropolitan Crematory * 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureins Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 1000 23a. Pert 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic Aneurysm **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Vascular Disease Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteo Arthritis has autop sy perform page certificate 1 Tyes 2 No 2 🔼 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 3 DOA 2 ER/Outpatient Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 Natural 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0051473 August 22, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Varnum St. N.E. #021 Washington, D.C. 20017 Kathy S. Brenneman, M.D. 31. Date filed (Month, Day, Year) AUG 2 4 2005 . Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yaai **Physician** 7:45 A.^M Sylvia H. Oseroff August 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1□M 2□F 19, 1909 Director 213-40-0852 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant. If a Misches Examination is not illicated once. Maria Yes 2 No Montgomery Bethesda Maryland Directo 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 5550 Tuckerman Lane, # 118 20852 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Minnie Needle Harry Weinberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stephen L. Oseroff - Son 10454 Buena Ventura Drive, Boca Raton, Florida 33498 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) United Hebrew Cemetery 8/23/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Banzansky Goldberg Memorial Chapels, Inc. 170 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Be Completed by Physician/Medical Examiner the burial-transit To tha Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 10 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION, CONGESTIVE HITHET FAILURE Division of Vital Records, 1 Yes No 3 Probably 4 Unknown EDEMA, MALNUTRITION, SICK SINVS SYNDROME 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? - CARCINDMA BREATT, FRAILITY Yes 2 No 25. Was case referred to medical examiner?
Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 9 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a e Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Suyamoundar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20878 10810 Darnestown Road, # 202, Gaithersburg, Maryland Rajan Shyamsunder, M. D. 31. Date filed (Month, Day, Year) 32 degistrar's Signature State 24 2005 MINGIAR! Registrar

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			_ FOI	Certificate of Death		2005	29375
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	dey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		ace (Stete or Foreign
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Division of	or Attence efter death Director:	Certification:	4 Homicide 4 Homicide 4 Homicide 4 See Place of Injury · At home, farr building, etc. (Specify)	m, street, factory, office	City or Town,	et and Number or Rural State)	Houte Number,
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2	or he hospital of Attending Prysician: within 24 hours elfer death. To the Funerell Director: After this certifica completely filled in by the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
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	Sta Registi		AUG 2 4 2005 Keeper & A	melle			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Name (If not institution, give street end number) 12.50 R 2005 /Medical 4c. County of Death Examiner 11901 Georgia 7. Age (In yrs. last bhilday) ManorCas heaton MC ave Year If Under 24 Hrs.
Hours Min. If Under 1 Months Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 20-806 1□ M 21 F Yrs. Danville, Va Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be rivilled. 1 Yes 2 □ No ashington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20001 Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
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If Yes, Give 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working tite. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Knowr ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Washington Dx 20001

20c. Location City or Town, State George 20b. Place of Disposition (N me of cemetery, crematory or other place, 20a. Method or Disposition

Burial 2 Gremation Lincoln Memorial 4 ☐ Donation 5 Other (Specify) 4925 N. H. Burroughs Avenue N.E. Washington DC 20019 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical FAILURE CHRONIC Examiner Physician/Medical Examiner the ettending physician and ched for use es the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence or). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 🗆 Yes 2 □ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2000 MUEN 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 4 2005 Registrar

DHMH 16 Rev 6/95

Yvonne M. Powell 05-5701 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	_	For State Registrar	State of M	narytanu 			te of L			R	•g. N2 0	05	2937
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Funeral Director		5. Social Security Number 6. Security Number 216–48–6675	7. /]M 2 🟋 =	Age (In yrs. Ias 46	t birthday) Yrs.	If Und Month	or 1 Year Days	If Under 24 Hr Hours Min	s. 8.	Date of Birth (Month, Day	1958	9. Birth Mary	place (State or Forei htry) Land
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ealth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Ty Robert J. Powell /						nd Number or F					
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he bur	edical Examiner	23a. Part1. Enter the disease complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	us a conseque	nce of):			. disease					Interval Between Onset and Death
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	Σ	29b. Signature and title of certifier Parallel Suid	half, MD	i death (lear)	22) (Tune	0	C.M.I			2	9d. Date sign Augus		
IVA	-	30. Name and address of person who co					enn St	treet, E	Balt	imore	,Maryl	and 2	21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 29378 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Day **Physician** 7:30 PM August 25, 2005 Michael Edward Powers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County 1112 Sunnyside Drive Hagerstown tf Under 1 Year tf Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb. 22, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M M 2 □ F 212-54-8536 1950 Maryland Director 55 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Executa-10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☑Yes 2 ☐ No Directo Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1112 Sunnyside Drive 21742 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dockman Trucking Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alfreda Yantz Thomas Lee Powers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 Sunnyside Drive Hagerstown, Maryland 21742 Jane Lee Powers / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Lawn Mem. Park Aug, 29, 2005 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home unola 1331 Eastern Blvd. N. Hagerstown, MD tire 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each tine. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** Pulmonary Fibrosis disease or condition years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetat death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Yes 2 No detached 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ischemic Cardiomyopathy, Diabetes Mellitus Type II 1 ☐ Yes 2 ☐ No 3 🖾 Probably 4 ☐ Unknown Completed Congestive Heart Failure 24a. Was an autopsy performe 24b. Were autopsy findings available prior to comptetion of cause of death? Aortic and Mitral Valve Disease 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo ို 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Intury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 signed by certificate or Attanding Physician: this Director: After death. within 24 hours a To the Funaral L

5H-10

State Registrar

DHMH 17 Rev 1/2001

Allen Ditto MD 31. Date filed (Month, Day, Year)

AUG 29 2005

747 Northern Avenue

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

32. Begistrar's Signature

D26806

Hagerstown, Maryland 21742

August 28, 2005

p	Amend 9/1/05		em #19a WCHD/SH	State of Ma	aryland	-	artment rtificate			ind M		giene No. 20	105	20	270
	Physicia		1. Decedent's Name (First, Middle, Las	,				-			2. Date of Dee Month	th Day	Year	3. Time o	100 AA
1	/Medic		Murl Francis POWE 4e Fecility Name (If not institution, give		***			4	b. City, Tov	wn, or Loc	ation of Deeth	4c. Count	2005 ty of Death	J ,	20 77
\mathbf{I}'	Examin	er	Julia Manor Nursi						Ная	gerst	own		hingto	n	
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. le	est birthdey)	If Under 1 Months	Year	If Under 2		8. Date of Birtl (Month, Day	1			or Foreign
	Director		236-20-1196 Usuel Residence of Decedent	DM 2□F 7	'9	Yrs.	Widitals	Days	Tiours	141111.	Oct. 6	1925			
	show		10a. State 10b. County		10c. City,	, Town or Lo	cation						10	d. Inside C	
	Sa-f	Ş	Maryland Washing	ton	Boor	isboro									2 ∑ No
	with th	吉	10e. Street end Number				10f. Zip C					10g. Citizen of	What Count	ry?	
	eath a 23	era	18532 Lappans Roa	12. Was Decedent	Ever in U.S	3. 13.1	Vas Decede		spanic Orio	nin? (Spe	cify Yes or No-	USA 14. Ra	ce - America	n Indian,	
20	permit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Heatth and Mantal Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28e-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2X I If Yes, Give Yeer or Dates:			fYes, specif 1□Yes 27/		n, Mexican Specify:	, Puerto I	cify Yes or No- Rican, etc.)		ack, White, e	tc.	
21215-0020	z hou	8	15. Decedent's Ed	ucation	-	16a. Deced	dent's Usual	Occupa	ation			16b. Kind of I			
215	nin 72	Completed	(Specify only highest gred Elementery/Secondary (0-12)	de completed) College (1-4or 5	5+)	(Give life. l	kind of work DO NOT use	done d retired	lurin g most ')	of workir	ng				
2	d wit	ĕ	8	0		Eng	ineer						road		
nd	d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,				
Maryland	Man Marke Marke	2	Francis Kadora Po					(0)			illian			2- (1)	
Ma	12 sh hand rism traun		19a. Informant's Name/Relationship (7)	Wife			_				Route Numbe			J0 0 (8)	
<u>ئ</u>	Healt	ŀ	June L. Powell -	W11e	20b. Pla		2 Lapp sition (Name netory or oth			і во	onsboro Date	20c. Location		n, State	
ē	ages ant of t: If it y or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				metory or oth wn Cre			Q /	26/05	Hagers	t our	Mars71	and
Baltimore,	artme ortan Injur		21. Signature of Funeral Service Licens		нав						nich Fu			Maryı	.anu
ä	permi Depar Impor any Ir	- 4	DONT!	Mun	u) S						Hagers			740	
	Discolation		23a. Part1. Enter the diseese, or comp shock, or heart failure. List only of	lications that caused ne cause on eech li	the death.	. Do not ent	er the mode	of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approxima Interval Be Onset and	tween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Conge	estive	e he	art f	ai	lure	_			1	leav.	Ś
	nsit	lical Examiner		. Ische	mic	as a consec	rdio	my	ора	Hy				lear	2
~	ate be executed hysician and the burial-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	VALV	Due to (or	as a consec	juence or):	hi	seas	P				V 00.	4.0
8760,	ysicia ysicia	cal	that initiated events	c.	Due to (or	as a conseq	uence of):	PI	3693					1441	
89 X	ding phr sa as th	/Med	resulting in death) Last	A	•	exo							l l	Year.	2
ñ	atten atten	ciar	Part II. Other significent conditions co					uso shu	on in Post I		22h Dist	obecco use c	ontribute to	the cause	of death?
P.O. Box 6	that the c ed by the detached	/ Physician/Mec	Type I	Drahe	tese	me	Mi Fu	17	siiniraiti.			es 2□No			Unknown
Division of Vital Records,	Physician: The law requires that tha death certifics this certificate has been signed by the attending ph ral diractor, page 2 should be detached for usa as t	eted by	Chronic	Obstru	ctive	e p	ulmer	nar	1 b)	L9 L 9		an autopsy med?	ava	re autopsy llable prior pletion of	to
= Rec	The law ate has page 2:	Completed	Atrial	fibrillo	tion	1			-		1□ Y	es 2XNo		eath? Yes 2] No
Zi Zi	clan: entific actor,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o				
o	Physic this ral dir	Ę.	1 ☐ Yes 2 No 27. Menner of Death	1 ☐ Inpatie	7	R/Outpatier 28b. Time or		,	4 X Nu		ne 5 🗆 Resid)	
on	dlng h. After fune	盲	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м	c. Injury Work	k? Yes 2⊟t			,.,			
Divisi	or Atten after deat Director: In by tha	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	me, farm, str	eet, factory,	office		2	28f. Location (S City or Tow	itreet and Num n, Stete)	nber or Rural	Route Nur	nber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has complataly filled in by the funeral director, page 2:	edicai C	29a. Certifier (Check only one)	sician: To the best of the basis of and manner sta	examineti	rledge, death on end/or in	n occurred at vestigation, i	t the tim	ne, date and pinion, deat	d place, a	nd due to the ced at the time, c	ause(s) and n date and place	nanner as sta e, and due to	ited. the cause(s)
	ro the	Mec	29b. Signature end title of pertifier						e number		2	29d. Date sign	ed (Month, L	ay, Year)	
	F > F 0) the	11					490			Augus		, 20	05
54	1-5		30. Name and address of person who d	ompleted cause of d	leeth (Item	23a) (Type,	Printap	nan	sRd	B				217	
	Sta Registr	te	31. Date filed (Month, Pay Year) 2	005 32. Filgistr	ar's Signati	y. A	ned								

		•	1 - For Stata Ragistrar	State of M	aryland / D	•		f Health of Deati		fental Hy	/giene	2005	5 293	80
	Dhyoisi		1. Decedent's Name (First, Middle, La			•				2. Date of D Month		y Yea	3. Time of D	eath
	Physici /Medio		Billie Ann Pecha							August	- 1			00A
	Examir	er	4a. Facility Name (If not institution, give	re street and number)		4	-	m, or Location	of Death			. County of D		
		M	Casey House 5. Social Security Number 6.5	Sex 7. Ac	ge (In yrs. last birt	hday) I	KOCK If Under 1 Ye	ville	r 24 Hrs.	8. Date of B	irth	Montgo	Birtholace (State or F	Foreign
	Funeral Director			1□M 2 Ž F		Yrs. N	Months Da	ys Hours	Min.	8. Date of B (Month, D Mar 2	7, Year)	953 No	rth Carol	ina
	D		Usual Residence of Decedent		10: Cit. T		**-						101 (-11-0)	4.1.
	shov	'n	10a. State 10b. County Maryland Montgom	orw	10c. City, Town								10d. Inside City 1 ☐ Yes 2	
	28a-f	ect	10e. Street and Number	ery	Germa	111 COW	10f. Zip Cod	10			10g Cit	izen of What		
	3a or	<u></u>	19515 Frederick	Road, Lot	#123		208						States	
	death	nera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	s Decedent	of Hispanic C	rigin? (Sp	ecity Yes or N Rican, etc.)	L	14. Race - A	merican Indian,	
98	or Ite	/ Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ If Yes, Give			Yes 22			moan, etc.)		Black, W Specify:		
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diesi Examiraer must be notified at	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	160	Doordoo	at's Havel Oa	· · ·		_	10h K	ind of Busine	White	
15	in 72 " nai	olete	(Specify only highest gr	ade completed)	10a.	(Give kin	nd of work do NOT use re	ocupation one during mo otired)	st of work	ring	100, K	INCOLOUSING	ss/moustry	
212	d with giene. rr thau	mo	Elementary/Secondary (0-12)	College (1-4or 2	5+)	Cust	omer	Servic	e			Hot	el	
D	al Hyg		17. Father's Name (First, Middle, Last	")						e (First, Middl	-			
yla	ould to Ment arked atic a	To Be	Lewis Thomasson							hea Fu				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic avant, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Me1 Pechacek/ Hu										a, Zip Code) 208	76
e,	1 and Health em 27 thar t		20a. Method of Disposition		20b. Place of	Dispositi	ion (Name o	1		Date			town, MD	
Baltimore,	ages in the state of the state		1 ☐ Burial 2 🖾 Cremation 3 [0000000	y, cremat	tory or other	place)	Aug	23,			a, Virgin:	ia
Ħ	artme ortan injury		' 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	1 1	\ \	_		1	•	Vol F				La
B	Depar Impor any ir		* Juffen !)	1th	N0 0689								urg, MD 20	0877
	NO.		23a. Part1 Enter the dilease, or com	plications that cause	d the death. Do n								Approximate Interval Betwe	
	Physician		Immediate Cause (Fin I disease or condition		static C								Onset and Demonths	ath
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	of):								
	Examine	<u>.</u>	Sequentially list conditions,	b. Due to /or or	a consequence o	of).								
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Ć.	be executed ician and burial-transif	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of	of):								
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9	certificate Iding phys		IF FEMALE:	907										
Вох	death certific e attending p ed for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ctopic pregna					23d. Date of o Month	delivery Day Yea	ar
	0 0 0	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐ Pregnant a 9□ Unknown	t time of death	5 ∐ O	ther (specify	/)					,	
P.O.	requires that the de een signed by the a nould be detached to	/ Ph	Part II. Other significant conditions	contributing to death t	out not resulting in	the unde	erlying cause	given in Par	f.	23e. Did	tobacco t	use contribute	to the cause of dea	ith?
ds	Se Dec	d by								1 🗆	Yes 2	Xi _{No} 3□	Probably 4 Uni	known
ecords,	y Q ts	Completed								24a. Wa		24b. Were	autopsy findings av	ailable
α	The lav	E O								perl	opsy formed? 2 🔯 No	death		se or
ita	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?							h (Check only	one)	1		
Division of Vital	Physician: this certific ral director,	မ	1 ☐ Yes 2 🔀 No		ent 2 ER/Out				lursing Ho				pecity) Hospi	ce
o uc	fter fter	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. T ay Year) Ir	ime of njury		Injury at Work? 1 ☐ Yes 2 [TNo	28d. Describe	how inju	ry occurred		
isio	Attanding r death. sctor: Afte by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not to	oe Diana of Im	jury - At home, far	rm. street			7140	28f. Location	(Street an	nd Number or	Rural Route Numbe	er.
Diγ	after after I Dire	ertii	4 Homicide determined	building, e	tc. (Specify)	,	,,				own, State			,
	To the Hospital or Attandir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner s	of examination and	, death or d/or inves	ccurred at th	ne time, date a my opinion, de	and place, eath occur	and due to the red at the time	e cause(s) , date and	and manner d place, and d	as stated. lue to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Lic	ense numbe			29d. Da	te signed <i>(M</i> c	onth, Day, Year)	
	4		Chila life	٠			D4	2452			Augu	st 22,	2005	
	1		30. Name and address of person who Chitra Rajagopal:					Road,	Rockv	ille, l	Maryl	and 20)850	
	Sta	-	31. Date filed (Month, Day, Year) AUG 24		rar's Signature			-						
	Regist	ar	AUG 64	ZUUJ J	AS SS	STORES								

State of Maryland / Department of Health and Mental Hygiens 29381 State
Registrar AMEND#20enMD, 9/1/05, BMW, McCo Certificate of Death Reg. No. 19, 2005 1. Decedent's Name (First, Middle, Last) 2. Date of Death AUG. Month **Physician** William The1man 5:13 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 8. Date of Birth (Month, Day, Year) Jan. 31, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min North Carolina 579-32-2499 75 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or 28a-f ehow the Modical Examiner hast be notified at Yes 2 No Director Hyattsville Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Riggs Road 20783 USA 238 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No 1947 — Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or Iteme 11. Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after to Department of Health and Mental Hygiene.
Importent: If item 27 1e marked other then "natural; or Item in yilury or other traumatic event, the Modical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Tailor Tailor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Patrick Vivian Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonja Marie Proctor/Niece 3420 27th Avenue, Temple Hills, MD. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 8-24-05 Alexandria, Va. 4 □Donation 5 □Other (Specify) 22. Name and Address of FacilityDeVol Funeral Home 21. Signature of Funeral Service License 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ eq 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this medition director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral o 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 5 Pending investigation 1 R Natural 1 ☐ Yes 2 ☐ No after death.

Director: Af 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifie 8-20-05 D45660 3 30. Name and address of person who completed cause of Seath (Item 23a) (Type, Print) Doinder Singh, CALCAN 1430C, 31. Date filed (Month, Day, Year) AUG 24 32 Registrar's Signature State 2005 Registrar

Physician

Funeral^{*} Director

Box 68760,	Attending Physician: The law requires that the death certificate be executed reach. Total. Sector: After this certificate has been signed by the ettending physicien and sector, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Liseasz	2
P.O. Box 6	that the death certified by the ettending I	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the undertying cause given in Part I.	23e. Did tobacco	
II Reco	The law reset to be page 2 sho	Completed		24a. Was an autopsy performed?	
Vita	siclan: certific irector,	Be	25. Was case referred to medical examiner? 26. Place of Death (Cf. 1) Place of Death (Cf. 2) Place of Death (Cf.		
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation 2 Pending (Month, Day Year) 3 Death 1 Vestigation 2 Sec. Injury Work? M 1 Yes 2 No	Describe how inj	
Divis	at or Atte s efter de il Directo d in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f.	Location (Street a City or Town, Sta	and Number or R te)
	fo the Hospital within 24 hours of To the Funeral I completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control on the basis of examination and/or investigation, in my opinion, death occurred a pand manner stated.	due to the cause(it the time, date ar	s) and manner a nd place, and du
	To the within 2 To the complete	Me	29b. Signature and title of certifier 29c. License number D 06419	29d. D	Sate signed (Mon $3-29$
	5/5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Dr. James Patrick Jarboe, 24035 Three Notch Road, Holly	wood, MD	20636
	Sta Registr		31. Date filed (Moluti Day (ear) - 32. Registal's Signature		

	Registrar			-	пітісаі	0 01 2	J 0 411 1			Reg. No.				
	1. Decedent's Name (First, Middl	e, Last)							2. Date of De	ath		3. Time of	of Death	
an al	Elizabeth Anne Qu	ıade							Month Aug	Day 27	/ Year 2005	8:25	Α.	
	4a. Facility Name (If not institution	n, give street and no	ımber)		4b. City.	Town, or	Location	of Death			County of Death			
	20252 Dt Toolsout	D = - 1												
-	20353 Pt. Lookout 5. Social Security Number	6. Sex	7 Ama //n um	innt hirthday		at Mi. 1Year	lls If Under	24 Hrs	0.0.4.4.0		St. Mary			
	·	1 M 2 DXF	7. Age (In yrs. 62	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da	y, Year)	9. Birth	place (State ountry)	or For	
<u> </u>	213-44-4094		02	TIS.					Mar 28,1	.943	Mary	land		
-	Usual Residence of Decedent						-							
.	10a. State 10b. County		10c. Cr	ty, Town or Lo	cation							10d. Inside C	ity Lir	
ַן כַּ	Maryland St.	Mary's	0	Great Mi	11s							1 🗌 Yes	, 2√	
Director	10e. Street and Number			77 000 1112	10f. Zi	Code				10a Citi	izen of What Cor	intn/2		
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a .	20353 Pt. Lookout F	Road				206	534				USA			
Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	I.S. 13.	Was Dece	dent of Hi	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	-	 Race - Amer Black, White 			
로	1 Never Married 2 Mar	ned 1 ☐ Yes	2 X No						7 110411, 010.7	-				
2	3∰Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 🗆 Yes	24 No	Ѕреспу:				Specify: Whi	te		
ط <u>و</u>	15. Deceder	it's Education		16a. Dece	dent's Lisu	al Occupa	ation			165 Ki	ind of Business/I	nductor		
Completed	(Specify only highe	st grade completed)	(Give	kind of wo	rk done d	turing mos	t of work	ing	TOD. K	110 01 002116221	ildustry		
욷	Elementary/Secondary (0-12)	College	(1-4or 5+)											
ပ္ပ	12		4	Social	Servi	ces Wo	rker			Soc	ial Servi	ces		
Be	17. Father's Name (First, Middle,	Last)				-	18. Moth	er's Nam	e (First, Middle,	Maiden	Sumame)			
	George Thomas Adams					}	Ç.	arah	Perry Ada	m a				
-	19a. Informant's Name/Relations			10h Maili	og Addross	/Street					r Town, State, Z	:- O- d-1		
				130. Walls	g Address	(31/001 8	uno remini	er or nur	ar noble wombe	ar, Cny o	I TOWIT, State, Z.	p Code)		
I	Patricia A. Lachkov	ic/Daughter		49681	Bay Fo	rrest	Road	, Lex	ington Pa	rk, M	D 20653			
1	20a. Method of Disposition			Place of Dispo cometery, crea			ا (م	1	Date	20c. Lo	cation - City or 1	own, State		
	1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State		-		1			~				
-	21. Signature of Funeral Service	9	HOI	y Face (· · · · · · · · · · · · · · · · · · ·	Aug 3.	1, 2005	Grea	t Mills, er Funera	Maryland	1	
	21. Signature of Puneral Service	The see of	1.	1	2. Name al	na Adares Rox 27	is of Facili	ny Mati	town, Mar	aruın vland	er Funera	I Home,	P.A	
	" wender	Harc	uner	, 1		, OIL 2,	о, дес	Jilai u	cown, Har	y Lanu	20030			
	23a. Part1 Enter the disease, or	complications that	caused the deal	th. Do not en	er the mod	le of dying	g, such as	cardiac	or respiratory ai	rest,		Approximat		
	shock) or heart failure. List	only one cause on	each line.		1	1	\ //		4			Interval Bet Onset and		
	Immediate Cause (Final disease or condition resulting in death) A Supplied Trailing in death Due to (or as a consequence of the condition of													
	resulting in dealtry	Due to	(or as a consec	nce of	121	λ	^					,,,	1	
			14.8	stron	w	Ate	in	AL	N.			11150	96O	
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to	(or as a consec	ence of)s					201			0000	~	
듣	Cause (Disease or injury	<	Und	1	2000	_ [700	all	Dua	242		1100	0	
Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consec	July	up	~)	VV	ui (Cura	asz		yea	IV	
		Due to	(or as a consec	(derice or).	/							Λ		
င္မ		d			4							U		
ed -														
	IF FEMALE:	23c. If yes, or	utcome of pregna	ancv							and Data of dali			
	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	aldeath 3[Ectopic p					'	23d. Date of delin Month		Year	
Physicia	1 ☐ Yes 2 ☐ No	4∐Preg 9☐Unki	nant at time of o	seath 5	Other (s	ecrfy)						/	- J-41	
ج ا	9 🗆 Unknown													
by P	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	ndertying o	ause give	n in Part I		23e. Did to	obacco u	ise contribute to	the cause of c	death1	
									101	res 2	PNo 3∏Pro	bably 4 □t	Unkno	
Completed														
ă									24a. Was		24b. Were aut	opsy findings	avail	
Ĕ									autor	rmed?	death?	ompletion of c	ause	
	05 Mar and 15								1 Tes		1 🗆 Yes	2∐ No		
ן מ	25. Was case referred to medica examiner?					16.		of Deat	h (Check only c	ne)				
<u> </u>	1 ☐ Yes 2 ♣ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 D0	OA Cthe	9r: 4 □ Nu	irsing Ho	me 5 Resid	dence (6 □Other (Spec	ity)		
	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	f	28c. Injury	at		28d. Describe I					
2	1 ■Natural 5 □ Pendir 2 □ Accident investi		iii, Day rear)	Injury	м	Work 1 □ `	<br Yes 2. ☐	No						
Ca	3 ☐ Suicide 6 ☐ Could	not be	a of Inium.	omo 4					206	Ctua - t	al Marian France	-10		
E	4 ☐ Homicide determ	nined 286. Plac	e of Injury - At h ling, etc. <i>(Specil</i>	ome, rarm, sti fy)	eet, factor	y, office			28f. Location (3 City or Tox		d Number or Rui)	ai Houte Num	nber,	
4)									Í					
5		ng Physician: To th	e best of my kno	owledge, deat	h occurred	at the tim	e, date an	nd place.	and due to the	cause(s)	and manner as	stated		
	29a. Certifier 1 Certifyii						.,	- P		(3)				
	Check only 2 Medical	Examiner: On the	basis of examina	ation and/or in	vestigation	, in my of	oinion, dea	th occur	red at the time,	date and	place, and due	to the cause(s	s)	
edical	one) 2 Medical	and mai	ner stated.	ation and/or in	vestigation	, in my of	oinion, dea	ith occur	red at the time,	date and	place, and due	to the cause(s	s)	
edical	Check only 2 Medical	and mai	basis of examina	ation and/or in	vestigation	, in my op	oinion, dea	th occur	red at the time,	date and 29d. Dat	place, and due	to the cause(s	s)	
edica	one) 2 Medical	and mai	basis of examina	ation and/or in	vestigation	, in my of	oinion, dea	LL9	red at the time,	date and 29d. Dat	place, and due	to the cause(s	s) 	

State of Maryland / Department of Health and Mental Hygiene - State Registrar 29383 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Cedric A. Rolle 1^{Day} August 9:37 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)
Nov. 15, 1929 Southern Maryland Hospital Prince George's 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 15M 20F 265-48-4498 75 Yrs. Bahamas Director Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28e-f show the Medical Examiner must be notified at 1 TYes 2 □ No Directo Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7602 Mason St. 20747 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "natural; any njury or other treumatic event, the Medical Example. 3 ☐ Widowed 4 ☐ Divorced **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) 10th College (1-4or 5+) Security Guard Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Rolle Annie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa M. Rolle - Wife 7602 Mason St., Forestville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery: 8/26/2005 Suitland, MD ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licensee Stewart Funeral Home 22. Name and Address of Facility 23a. Paint Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick or heart failure. List only one cause on example. 4001 Benning Rd., N.E. Wash., DC 20019 Interval Between Immedia e Lause (Final disease of Jondition resulting in death) Onset and Death **Physician** unline. /Medical Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? USSTRUCTIO 3 Probably 4 Honknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Ho 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 10 entifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Description Description (as the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 045 20 er o completed cause of death (Item 23a) (Type, Print) Arastoo Vaz ani, M.D Ave 3-41 MD onsi-31. Date filed (Month, Day, Year) State 2 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene. Reg. No.2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST Physician 27 2005 8:00PM JULIUS THOMAS REQUARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TALBOT EASTON 51 DAVIS LANE 7. Age (In yrs. last birthday)

8. Date of Birth
Months Days Hours Min.

1. July 4 1 919 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** MARYLAND 1**X**M 2□F 86 Director 212-18-9442 Usual Residence of Decedent 10d. tnside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County rthan "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Director TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 51 DAVIS LANE 21601 **IISA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 4 Elementary/Secondary (0-12) othar than INVESTER REAL ESTATE permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygiel
Important: If item 27 is marked other It
any Injury or other traumatic event, Ite
2006. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATHERINE FELLING JULIUS HERRMANN REQUARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 51 DAVIS LANE, EASTON, MD 21601 ELEANOR B. REQUARD/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 8/29/2005 STEVENSVILLE, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee JOHN R. MERCERO 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes 1 Yes Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1_Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: of in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 125750 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ M.D. 508 IDLEWILD AVE. EASTON, MD 21601 2. Registrar's Signature 31. Date filed (Month Da ď State Registrar

				Ce.	artmen rtificat	t of H e of L	ealth a	and M	Re	g. No LU	05	29385
	Physici /Medic		Decedent's Name (First, Middle, Last) ROY MARION RICKERDS						2. Date of Death Month	Day	Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL		4b. City,	Town, or	Location of HAGE	of Death				HINGTON
	Funeral Director			thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth OC Tonth. Per.	^Y •¶927	9. Birthi	place (State or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND WASHINGTON 10c. City, Town	n or Lo	ocation	KNO	OXVIL	LE				10d. Inside City Limits 1 ☐ Yes ② No
	3a or 28e	Il Director	10e. Street and Number 1415 WEVERTON ROAD		10f. Zip	Code	217	758	10	g. Citizen of \	What Cou	,
036	urs after deatl el', or Items 2 Exeminer mu	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Arried Forces? 1 ☑ Yes 2 □ No 1945 − If Yes, Give Year or Dates: 1946		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spo	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. HTTE
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show appringly or other traumatic event, the Medical Enaulier must be notified at anote.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired,	uring mos		ing	6b. Kind of B		dustry
land ?	uld be filed Aental Hyg rked other tlc event,	To Be C	17. Father's Name (First, Middle, Last) GEORGE D. RICKERDS						OBLENTZ	laiden Suman	78)	
	and 2 shouealth and Market in 27 is mainer traumainer t		DOLORES L. RICKERDS, SPOUSE 14	415	WEVE	RTON		, KN	al Route Number.			21758
altimore,	Pages 1 Iment of H tent: If iter		*4 Donation 5 Other (Specify)	y, crei VIL	LE HG	TS. (CEM.	9/2/	² 2005	BROWNS		e, MARYLAND
Ball	Departic Departic Importe any inju		21. Signature of Funeral Section 19 Kell A. A. Printer A.			FUN	ERAL	HOME	BOONS	OLD NAT BORO, M	'IONA IARYL	AND 21713
	Physician /Medical Examiner purial-transit	Examiner	23a. Part. Enter the displase, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the cause).	of):		e or dying	, such as	cardiac (n respiratory arre	St,		Approximate Interval Between Onset and Death
). Box 68760,	ath certificate attending phy for use as the	Physician/Medical Ex	d	3[Ectopic pr					23d. Dat	e of delive	ery Day Year
rds, P.O	quires that the de n signed by the a lid be detached i	by	Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying c	ause give	n in Part I.			acco use cont	ribute to th	ne cause of death?
Vital Records,		e Completed	25. Was case referred to medical				26 Plano	of Dooth	24a. Was an autopsy perform	No 1	Were auto prior to con death?	psy findings available mpletion of cause of
Division of Vi	Phys this ral di	Certification; To Be	examiner? 1	ime of	f 2	8c. Injury Work 1 🗆 Y	r: 4□ Nu	rsing Hor	me 5 ☐ Resider 28d. Describe ho	nce 6 ⊡Other	ed	
Σ	or A after Direction by		4 Homicide determined 286. Place of thiury: At nome, far building, etc. (Specify)						28f. Location (Str. City or Town,	State)		
	To the Hospital within 24 hours and to the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated.	death d/or in	n occurred vestigation,	at the time in my op	e, date and inion, deal	d place, a	and due to the ca ed at the time, da	use(s) and ma te and place, a	nner as si and due to	ated. the cause(s)
•	Mith To 1	2	29b. Signature and title of certifier		290	License	number	19U	29	d. Date signed	(Month,	Day, Year)
1	5+1		30. Name and address of person who completed cause of death (Item 23a) (Dr. Kuggin buthum 1110	Туре,	Print) Helics	el (Jam	pas	Rd. 1.	tra. 1	Md	21740
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 3 1 2005	4	che		0			7		

			1 - For State of Maryland / Department	artment of Health and Mental Hy rtificate of Death	/gien 2 0 0 5 2 9 3 8 6
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Charlie L. Scott	2. Date of Di Month A Le La	paath Day Year 3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number) 1040/ Inez //ace	4b. City, Town, or Location of Death	46. County of Death
	Funeral Director		5. Social Security Number 239-15-4129 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. Jan.	orth 9. Birthplace (State or Foreign New Bern, N.C.
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		10d. Inside City Limits
	vith the Mi	Directo	Maryland Prince George Clinton 10e. Street and Number 10401 Inez Street	10f. Zip Code	1
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show appringury or other traumatic event, it a Modical Exercitien man be notified at appres.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 → No	20735 Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☑ No Specify:	United States 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	l within 72 hou lene. r than "natura it e Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Inter	16b. Kind of Business/Industry Private
Maryland 2	uld be filed Jental Hyg rkad other	To Be C	17. Father's Name (First, Middle, Last) Luther Scott	18. Mother's Name (First, Middle Unknown	o, Maiden Sumame)
	nd 2 sho lith and 1 27 is ma r traums			ng Address (Street and Number or Rural Route Numb King Lewis Dr. Alexandr	, , , , , , , , , , , , , , , , , , , ,
altimore,	Pages 1 a ment of Hes ant: If Item ury or othe		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Date natory or other place)	20c. Location - City or Town, State Alexandria, Va.
Balt	permit. Departimont. Import. any inj		21. Signature of Funeral Service Lorinsee 22	Alexander Scill Pope Funer 5538 Mariboro Pike/Fore	al Homes, P.A. 20747
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		
50,	icate be executed physicien and sthe burial-transit	i Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):		
68760,		Medicai	d		
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy] Other (specify)	23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un		tobacco use contribute to the cause of death? Yes 2 \(\text{No} \) No 3 \(\text{Probably} \) Probably 4-\(\frac{4}{200} \text{nknown} \)
Vital Records,		Completed		24a. Was auto perf 1 ☐ Yes	
	ys di S	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26. Place of Death (Check only of 3 DOA Other: 4 Nursing Home 5 Res	
Division of	tending Ph death. tor; After th the funeral	ertification: 7	CE Could with	28c. Injury at Work? 28d. Describe Work? 4 injury at hims	how injury occurred Shot
ΟĬΧΪ	ital or Attenders rs after deathral Director; led in by the	Certifi	4 Homicide determined building, etc. (Specify)	eet, factory, office 28f. Location (City or To	treet and Number or Rural Route Number, wn, State) 1040; Inel Clinton My
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; Attercompletely filled in by the fune	ledicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death part of the basis of examination and/or invariant manner stated.	vestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
)	with To To	Σ	29b. Signature and title of certifier Alachado hlosto Do	29c. License number 150555927	29d. Date signed (Month, Day, Year) August 17: 20% 5
_	(4)		30. Name and address of person who completed cause of death (Item 23a) (Type, SALVADOV SYLVETE, 3001 Hospital		n land
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 4 2005 AUG 2 4 2005	W.	/

		1 - For State Registrar		arylan	d / Depa	artment of H rtificate of L	ealth an Death		Reg. No.	005	293	
Physicia /Medic		Decedent's Name (First, Middle, Joseph Barton						2. Date of D Month 08	eath 19	2005	3. Time of 10:43	Death A ^M
Examin		4a. Fecility Name (If not institution, Washington Adve	ntist Hospi	tal		4b. City, Town, or Takoma			Mon	ounty of Deeth	У	
Funeral Director		5. Social Security Number 578-24-9063 Usual Residence of Decedent	6. Sex 7. Ag	81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, L	orth 6/1924 6/1924	9. Birth Cou Miss	place (State of ntry) issippi	Foreigr L
Maryland	tor	DC 10b. County			y, Town or Lo						10d. Inside Cit 1	
h with the 23a or 28	Funeral Director	10e. Street and Number 4819 Seve	enth Street	N.E.		10f. Zip Code 20017	,		10g. Citize	n of What Cou	ntry?	
72 hours after death with the Marylan "natural, or Items 23a or 28a-f show dical Examiner must be rediffed at	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3√2 Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ad 1 Types 2 1 If Yes, Give Year or Dates:	?		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin n, Mexican, P Specify:	i? (Specify Yes or Nouerto Rican, etc.)		Race - Ameri Black, White pecify: Bla	etc.	
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ite has been signed by the attending physbage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)			230	d. Date of delive Month		ear /
n signed b	by	Part II. Other significant condition	ns contributing to death I	but not res	sulting in the u	inderlying cause give	en in Part I.			contribute to		
	e Completed	25. Was case referred to medical	When's	D. / J.	CVA	réase chou	wino	1⊆ Yes	opsy formed? 2X No	24b. Were aut prior to codeath?	opsy findings a completion of ca	avariable of
ter this	Certification: To Be	examiner? 1 Yes 2X No 27. Manner Death 1 Autural 5 Pendin 2 Accident investig 3 Suicide 6 Could n	ation of he	ury ay Year)	28b. Time of Injury	M 1 🗆	4 Nursi	ing Home 5 🗍 Re 28d. Describ	sidence 6 [e how injury o	occurred		
o the Hospital or Attending Physician; iithin 24 hours after death. o the Funeral Director; After this certifica completely filled in by the funeral director.		4 Homicide determine 4 Homicide 29a. Certifier 1 Certifyin	g Physician: To the best	tc. (Special	owledge, deat	h occurred at the time	ne, date and c	City or 7	own, State) e cause(s) ar	Vumber or Rui	stated.	
o the Hospital of Attendum Mithin 24 hours after death. To the Funeral Director: At completely filled in by the fu	Medical	(Check only 2 Medical (one) 29b. Signature and title of certifier	and manner s	of examinated.	ation and/or in	29c. Licenso	e number	occurred at the time	29d. Date s	signed (Month	Day, Year)	
by St.	ite	30. Name and address of person of the state	upta Was	shine	ton Adature	Print) duentist	tosp."	1600 Ca	reoll.	Aug.	Takenic	PK

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year AUGUST 2:45A M GRACE ELAINE SAVOY 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CAPITOL HEIGHTS

If Under 1 Year If Under 24 Hrs. 8

Months Days Hours Min. PRINCE GEORGES 6303 CARRINGTON COURT 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M **20X**F Director Yrs 27, 1930 MARYLAND 220 26 0413 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Te marked other than "natural", or Items 23a or 28e-f show treumatic event, the Medical Exert are must be morified at XXYes 2 □ No Director MARYLAND PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10251 PRINCE PLACE #T4 20774 UNITED STATES filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH COSMETOLOGIST PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil iment of Health and Mental H tant: If item 27 le marked otf MAUDE ALBERTA JONES WILLIAM SAVOY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11324 KETTERING TERR. UPPER MARLBORO, MD 20774 WARREN L. SAVOY / SON other i 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 5 permit. Page Department of Important: If any injury or once. RESSURECTION CEMETERY 08/29/2005 CLINTON, MD 21. Signature of Funeral Service Licensee नै। 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. SULLLAND, MD 20/46 4308 SULTLAND ROAD . nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CANCER OF PANCREAS 8 MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician end for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached to 1 ☐ Yes 2XXNo P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by **ASTHMA** 1 Yes XX No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes XXNo 1 Yes 2 No 1 Yes or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) SISTER'S Other: 4 Nursing Home 5 Residence XX Other (Specify) RESIDENCE Hospital: 2 1 ☐ Yes XX No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After XXNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funerel XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number AUGUST 22, 2005 D13339 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. CHANCHIEN, M.D. 8824 CUNNINGHAM DR. BERWYN HEIGHTS, MD 31. Date filed (Month, Day, Year) State AUG 2 5 2005 Registrar

DHMH 17 Rev 1/2001

Box 68760

State of Maryland / Department of Health and Mental Hygiene 2005 29389 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Helmut Schade 24, 2005 8:25 p.m. August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Dowe11 13915 Dowell Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 X M 2 □ F 79^{Yrs.} 5-18-26 Germany Director 577-44-8782 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examinar must be multiled at 1 ☐ Yes 2 ☑ No Director Calvert Dowe 11 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 13915 Dowell Road 20629 United States death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11 Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 1 No Specify: Specify: White 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education grade completed) (Specify only highest Complet College (1-4or 5+) Elementary/Secondary (0-12) Furniture Furniture Refinisher 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event. Be Anstreicher Otto Schade Agnes Therese Zabel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13915 Dowell Road, Dowell, MD 20629 Virginia Schade/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 8-26-2005 Charlotte Hall, MD Brinsfield-Echols Cr 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature Fineral Service DOC Edward N. Brinsfield, Jr. 22955 Hollywood Road, Leonardtown, MD 20650 M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic 6 months lung **Physician** Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy this certificate has 2 No 1 Yes 2 No 1 Tyes 26. Place of Death Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending To the Front after death.

To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D25156 harles Bernett 40 August 25, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Bennett, 11845 H.G. Truman Road, Lusby, MD 20657 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 9 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Ragistrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	ealth and M Death	ental Hygie	ene 200	5 29390
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Media		Jack Teation SHRA	DER				Month August	27, 2005	21:10 M
	Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			19 Brent Street			Hancock			Wash	nington
l	Funeral Director		5. Social Security Number 6. Sec. 1219-20-3312		. last birthday) 79 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear) Co	thplace (State or Foreign Duntry)
	pu *		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Lo	antina				1011-11-01-11
	sho	ō			ity, Town of Lo					10d. Inside City Limits
	the N	Directo	Maryland Washing	LOII		Hagerst	OWN	100	. Citizen of What Co	
	with Sa or		1159 Hamilton Boul	evard			742	109	USA	ountry?
	death ms 20	Funeral		12. Was Decedent Ever in U		Was Decedent of His	spanic Origin? (Spe	cify Yes or No-	14. Race - Ame	erican Indian,
9	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show Jical Executant, and be prefilled at	Fur	1 Never Married 2 Married	Armed Forces? 1 ZYes 2 □ No		Yes, specify Cubar		Rican, etc.)	Black, Whit	e, etc.
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2121	withir sne. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	carn	00 NOT use retired) I a n			railro	vad
р 7	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or itams 23e or 28e-f show aumatic event, it a Medical Executer to ast be retilled at	e Co	17. Father's Name (First, Middle, Last)	0	Carn		18. Mother's Name	(First, Middle, Ma.		au .
Maryland	ld be ental kad o	~	George William Shr	ader					enberger	
ar.	should be and Mental Be marked o	-	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailin	g Address (Street a			ity or Town, State, 2	Zip Code)
	and 2 Balth a n 27 lg	18	Robert L. Shrader	- son					and 21750	
altimore,	ter oth		20a. Method of Disposition	1	Place of Dispo	sition (Name of natory or other place	D	ate 20	c. Location - City or	Town, State
Ē	permit. Pages Department of I Important: If it any injury or o		1X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)			Cemetery		31,2005	Hagerstow	m, Maryland
a	rmit. partn ports y inju		21. Signature of Funeral Service License	m: /	22	. Name and Address	s of Facility	INNICH F	UNERAL HO	ME
<u>m</u>	8 3 5 8 8		CANUI	Januar					town, Md.	21740
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	ations that caused the dea e cause on each line.	th. Do not ente	er the mode of dying	, such as cardiac o	r respiratory arrest		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):					
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89	ificate g phys as the	edlcal								
Box	eath certifi attending I for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn 1□Live birth 2□Feta		F-4i			23d. Date of deli	ivery
	0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of a		Ectopic pregnancy Other (specify)			Month	Day Year
<u>.</u>	at the de by the a stached	2hys	9 🗆 Unknown							
	res tha igned I be det	by	Part II. Other significant conditions con	tributing to death but not re-	sulting in the ur	derlying cause giver	n in Part I.			the cause of death?
ord	w require been sig	ted						1 X Yes	2 □ No 3 □ Pro	obably 4 Unknown
Records,	The law requires that the tee has been signed by the bage 2 should be detache	Completed						24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E		Cor						performed 1 ☐ Yes 2 🛣		2 No
Vital	sician: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Death	at a state of the		son's
	Phys this ral dia	-T	1 ☐ Yes 2 ☒ No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient	3 DOA	4 Nursing Hon	ne 5 Residenc 8d. Describe how	e 6 K Other (Spec	residence
Division of	ding F h. After funer	tion	1 X Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work? M 1 7	es 2 🗆 No	od. Describe now	injury occurred	
18	I or Attandi after death. Director: A I in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, stre			8f. Location (Stree	t and Number or Ru	ral Route Number.
2	after after Direction by	Certification:	4 Homicide	building, etc. (Speci	fy)	, , , , , , , , , , , , , , , , , , , ,		City or Town, S	itate)	
	a Hospital 24 hours a a Funeral Detely filled		29a. Certifier 1X Certifying Phys	ician: To the best of my kno	owledge, death	occurred at the time	e, date and place, a	nd due to the caus	e(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	ation and/or inv	estigation, in my opi	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		\	29c. License	number	29d.	Date signed (Month	n. Day, Year)
			Mught	one	wo le	D	4647	3.	8/2	4105
, [30. Name and address of person who con			- A	1	À 3:5	11	
) 	1-4+1		31. Date filed (Month, Day, Year)	D 1130 00a 32. Registrar's Signi	1 Court	Hagers	town, M	D 217	70	
	Sta Registr		AUG 3 0 20	05	H. 1	rested				
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	Physi	cian	Decedent's Name (First, Middle, Last	,						2	2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Me	dical	Caroline Frances 4a. Facility Name (If not institution, give				4h Cih	Tours or	Location of	of Dooth	10605		2005 ty of Death	5:15 AM
	Exan	niner							Location	oi Dealii				
	Funera	al	Doctors Community 5. Social Security Number 6. Se	x 7. Ag	e (In yrs.	last birthday	/) If Under Months	1 Year	If Under Hours	24 Hrs. 8	B. Date of Birt	lo.	O District	orge's
	Directo		210 00 , 10,]M 2₩F	8	1 Yrs.	MOHITIS	Days	riouis	J.	une 17	1924	Wash	ington, DC
B	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or I	ocation						1	0d. Inside City Limits
2	Marylan f show	ō	Maryland Prince G	eorge's		Collec	ge Par	k						1 ☐ Yes 2 🏝 No
ANCE	r 28a-f show	Director	10e. Street and Number		1		10f. Zip					10g. Citizen o	f What Cour	ntry?
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		Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13	. Was Deced	ent of Hi	spanic Ori n, Mexican	igin? (Spec	ify Yes or No- ican, etc.)	14. Ra	ace - Americ	
ני	36 safte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Yes 2XX If Yes, Give Year or Dates:	No		1 ☐ Yes 2	2 DeNo	Specify:			Spec	ify: W	hite
3	1215-0036 within 72 hours after and 72 hours after and 72 hours after than "natural", or its the Modical Examples		15. Decedent's Edu	cation			edent's Usua					16b. Kind of	Business/In	dustry
Jeein	215 Fig. 72	Completed	(Specify only highest grad	de completed) College (1-4or :	5+)	(Giv life.	e kind of wor DO NOT us	k done d e retired;	uring mos	t of working	7	Depart	ment	of Defense,
1,0	ind 212 be filed with tal Hygiene. d other than	Con	12			Admi	nistra	tive				U.S. G		ment
3	be fill Hydra doth	Be	17. Father's Name (First, Middle, Last)									Maideri Suma		
	should and Men	2	Guy Albert Spigo			10h Mai	ling Addross	(Street o				la Giar		Cadal
3	Maryland 2121 nd 2 should be filed withir lith and Mental Hygiene. 27 is marked other than r traumatic event, tra M		Joan A. Browning/		E Will	1	-	-				rk, Mai		
SICONE	altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours alt partment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural", or yinjuryor other traumatic event, the Medical Exami		20a. Method of Disposition		20b. F	Place of Dist	oosition (Nan	ne of	Ţ	Da	te	20c. Location		
10	Pages nent of nt: If if	9	1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify,				eaven Ce			_	st 26	Silver	Sprin	ıg, Marylan
S	Baltimore, N permit. Pages 1 and Department of Health important: If Item 27 any injury or other ti	9	21. Signature of Funeral Service Licens	600		j	22. Name an	d Addres	s of Facili			Home		ig, naryran
-	o 89 E 8	8	Charas S	Soul .	De	į	500 Un	iver	sity	Blvd,	W, Si	lver S	pring	, MD 20901
•	Physicia /Medica Examine	al	23a. Part. Elter the disease, or comp shock, of heart failure. List only of limited in the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as	ne. on o a conseq e o	uence of):	anc		, such as	cardiac or	гезрпатогу ап	resi,		Approximate Interval Between Onset and Death
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	Division of Vital Records, P.O. Box 6 to Attending Physician: The law requires that the death certific affer death. Director: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	I death 3	□Ectopic pro □ Other (sp						ate of delive	ery Day Year
	rds, F quires tha en signed l	b	Part II. Other significant conditions co	niributing to death b	out not res	ulting in the	underlying ca	ause give	n in Part I			obacco use co ′es 2 □ No		ne cause of death? ably 4 []Uriknown
	I Record The law requirate has been page 2 should	Completed									24a. Was a autop perfor	an 24b sy med? 2 No	. Were auto prior to cor death?	psy findings available npletion of cause of
	Vital F iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?							of Death (Check only o	ne)		
	of Vil	၉	T Tes 2 NO	Hospital: 1 Inpatio		ER/Outpati						lence 6 🗆 O		/)
	ding F After funera	ion:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time Injury	of 2	Bc. Injury Work	at ? ′es 2 □		id. Describe h	ow injury occu	irred	
	Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, el	ury - At ho c. <i>(Specif</i>	ome, farm, s			95 2		f. Location (S City or Tow	Street and Nun m, State)	nber or Rura	l Route Number,
	Hospitai 24 hours a Funerai I	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best iner: On the basis of and manner st	it examina	wiedge, dea	ath occurred and investigation,	at the tim in my op	e, date an inion, dea	d place, an	d due to the o	ause(s) and r	nanner as st	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c	. License	number			29d. Date sign	ed (Month,	Day, Year)
	1		MAnin	m		•			53			AUCUSI	-00,	2005
	9		30. Name and address of person who c	ompleted cause of o	death (Iten	n 23a) (Type	e, Print)					AUREL.		
			THOMAS IHAW 550 31. Date filed (Month, Day, Year)	10 19.10 38. Registi	57	5 MM	IN 57,	11867	- 50	1760	153 6	-AUREL	MD.	20767
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Registrar

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

				artment of Health and Natificate of Death	Mental Hygie	°°2005 29393
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Rita C. Sheffery 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month August 1	Day Year 3. Time of Death 3:35 P M
	Examir Funeral Director	ner	Brighton Gardens 5. Social Security Number 6. Sex 1 M 2 F 80 Yrs.	Chevy Chase If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo May 27, 1	4c. County of Death Montgomery 9. Birthplace (State or Foreign Country) 925 Washington D.C.
ore, Maryland 21215-0036	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland. Depertment of Heath and Mental Hygiene. Important: If lien 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Ever it are must be indiffed at once.	To Be Completed by Funeral Director	1 Yes XXNo If Yes (Sive Year or Dates: 15. Decedent's Education 16a. Dece Give Year or Dates: 15. Decedent's Education 16a. Dece Give Year or Dates: 15. Decedent's Education 16a. Dece Give Year or Dates: 16a. Decedent's Education 16a. Dece Give	ase 10f. Zip Code 20815 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto □ Yes 2 ☒ No Specify: dent's Usual Occupation kind of work done during most of work DO NOT use retired memaker 18. Mother's Name Charlott ng Address (Street and Number or Rura Falmouth Rd. Beth psition (Name of	ecity Yes or No-Rican, etc.) ing 16t e (First, Middle, Mail e Bailey al Route Number, Collega, Mar Date 20c	10d. Inside City Limits 1 💆 Yes 2 □ No Citizen of What Country? I.S.A. 14. Race - American Indian, Black, White, etc. Specify: White D. Kind of Business/Industry Why Home den Sumame) ify or Town, State, Zip Code)
Baltimore,	permit. Page Depertment of Important: if any injuty or once.		*4 Donation 5 Other (Specify) MT Comformation 12. Signature of Funeral Service Licensee	rt Crematory 20 2. Name and Address of Facility Jos	eph Gawle	exandria, Va. r's Sons, Inc. hington, D.C. 20016
E	Thy see detached for use as the burial-transit ped detached for use	lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	erthe mode of dying, such as cardiac o		Approximate Interval Between Onset and Death Months
O. Box b	the attending p	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	peen s	Completed by	Part II. Other significant conditions contributing to death but not resulting in the unadvanced dementia	nderlying cause given in Part I.		24b. Were autopsy findings available prior to completion of cause of death? 1
VISION	iffer death. Director: After	Certification: To Be	25. Was case referred to medical examiner? 1	28c. Injury at Work? M 1 Yes 2 No	me 5 Nesidence 28d. Describe how in	and Number or Rural Route Number,
	within 24 hours after To the Funeral Dir completely filled in	Medical Ce	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	a occurred at the time, date and place, a restigation, in my opinion, death occurred 29c. License number	ed at the time, date a	o(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
;	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Lile McConnell, M.D. 5530 Wisconsi 31. Date filed (Month, Day, Year) AUG 2 4 2005	n Ave. Suite 1400		ase, Md. 20016

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** IVia 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner General Hospital Montagnery MONTGOMERY OLNEY If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2X F 86 ILLINOIS FEB. 03, 1919 Director 358-01-4183 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MARYLAND MONTGOMERY SILVER SPRING Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 3701 INTERNATIONAL DRIVE, # 207 Items 23a 20906 permit. Pages 1 and 2 should be filed within 72 hours after death v Inportant of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, Ite Medical Exacilinations. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 (XNo □Yes 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: If Yes, Give Year or Dates: WHITE 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES ROSE MILLER BERNSTEIN 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD SCHUTZ - SON 6004 RIDGE FORD, BURKE, VA 22015 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL 2005 FALLS CHURCH VIRGINIA AUG 23. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1DANZANSKY GOLDBERG, MEMORIAL CHAPELS 08520. HOUN 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I schemic Stroke Physician wknown disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Physician/Medical Examiner Preumonia To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit physician and Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 menths? 1 ☐ Yes 2 Ø No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á determined 4 T Homicide within 24 hours after To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BH9297068 12005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Monta M.D. at General florgital in Olney ROBERT Homes 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 2005 AUG Registrar

	1- For Amend Item1&U	Jnpend Item 23	3a,ptody	tiffcate of	Death 47	9-12-05	tas 201	05 293
Physician /Medical	1. Decedent's Name (First, Middle, Las	O .	Tan	i-01u		2. Date of Deat Month August	_	3. Time of Dea Year 2005 2200
Examiner	4a. Facility Name (If not institution, give Laurel Regional		tau		or Location of Dec ${ m e}1$		4c. County o	e George's
Funeral Director	216 43 9181	9x 7. Age (In yrs 30	s. last birthday) Yrs.	If Under 1 Year Months Days				9. Birthplace (State or Fo Country) Nigeria
s or 28a-f show be notified at Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom		rookevi	11e				10d. Inside City Li
13a or 2 at be n				10f. Zip Code	20833	10	Og. Citizen of Wi	nat Country?
atal Hygiene. d other than "natural", or iteme 23a or 28a-f ehow avent, the Medical Evertinar must be notified at avent, the Medical Evertinar must be notified at Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	Yes, specify Cub ☐ Yes 2 No	Specify:		14. Race Black Specify:	- American Indian, , White, etc. Black
Hygiene. ther than "nature int, tre Medical E Completed	15. Decedent's Ed (Specify only highest grad	College (1-4or 5+)	(Give k	O NOT use retire	during most of w	orking	16b. Kind of Bus	.,
Mental Hygi arked other atic avent, I To Be Cc	17. Father's Name (First, Middle, Last)					ame (First, Middle, N)
ment of Health and Ments ent: if itam 27 Is marked jury or other traumatic a	19a. Informant's Name/Relationship (7	ype, Print)			and Number or I	Rural Route Number,	City or Town, S.	
n 27 ls	Kayode Tani-Olu /	Brother	2163	2 Gentry	Lane Bi	ookeville	,Maryla	nd 20833
ng physicien and ses the burial-transit and ses the burial-transit and leading the second sec	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Chronic Ren Due to (or as a conse b. Due to (or as a conse c. Due to (or as a conse d.	quence of): quence of):	ase				Onset and Dea
signed by the attending properties of the detached for use as by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldéath 3∏6 death 5∏	Ectopic pregnanc Other (specify) _			23d. Date Month	•
be of	Part II. Other significant conditions of Hypertensive Card					4		ute to the cause of death
ste hes page 2	25. Was case referred to medical			71			ned? de: □ No 1/2	ere autopsy findings avai or to completion of cause ath? √es 2□ No
frer this uneral dis	examiner? 1	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injui	ner: 4 ☐ Nursing	Home 5 Resider 28d. Describe how	nce 6 Other	
urs etter	3 Suicide 6 Could not be					28f. Location (Street and Number or Rural Route City or Town, State)		or Rural Route Number
0 = +	4 Homicide determined	building, etc. (Spec	ify) 		ma data d - l	City or Town,	State)	
he Fund pletely f	4 Homicide determined 29a. Certifier 1 Certifying Phy	200. Place of injury - At I	ify)	occurred at the ti	me, date and plac	City or Town,	State)	ner as stated
within 24 hours efter death. To the Funeral Director: A completely filled in by the ti Medical Certificati	4 Homicide determined 29a. Certifier 1 Certifying Phy	building, etc. (Spec	ify)	occurred at the tilestigation, in my c	ppinion, death occ se number	City or Town, se, and due to the cal surred at the time, da	use(s) and mannite and place, and	ner as stated. d due to the cause(s) Month, Day, Year)
within 24 ho To the Fund completely f	4 Homicide determined 29a. Certifier 1 Certifying Phyone) 2 Medical Example	puilding, etc. (Special Specia	ify) lowledge, death atton and/or inve	occurred at the tinestigation, in my of 29c. Licens	ppinion, death occ	City or Town, se, and due to the cal surred at the time, da	use(s) and mannite and place, and	ner as stated. d due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29396 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2^{Day} Month Aug **Physician** 2005 Robert A. Thompson, Sr. 12:30 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 22695 Maddox Road Bushwood St. Mary's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1**√** M 2□ F Months Days 62 Yrs Director 214-42-4241 Jan 08,1943 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rai", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Directo Maryland St. Mary's 1 ☐ Yes 2 🔯 No Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22695 Maddox Road Funeral 20618 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 € Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2☐ No Be Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 911 Dispatcher U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ Thomas Bertrand Thompson, Sr. Louise Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 other tru Myrtle B. Thompson/Wife P. O. Box 12, Avenue, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any Injury or of once. 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery Aug 30, 2005 Bushwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A., P. O. Box 270, Leonardtown, Maryland 20650 **Physician** /Medical Examiner Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innertal infector, page 2 should be detected for use as the burial-transit completely filled in by the Innertal director, page 2 should be detected for use as the burial-transit Division of Vital Records, P.O. Box 68760.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. METASTA		NG CANC			Interv	al Between and Death
		Due to (or as a conse	quence of):					
xamine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
dical E		Due to (or as a consect	quence or):					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 DEctopi	c pregnancy (specify)		23d. Date of de Month	blivery Day	Year
ted by P	Part II. Other significant conditions	contributing to death but not re-	sulting in the underlyin	ig cause given in Part I.	23e. Did tobacc	o use contribute to		e of death?
					24a. Was an autopsy performed	prior to death?	utopsy find completion s 2 \(\text{No.}	lings available to of cause of
e n	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)			
2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Soe	acify)	
ation:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigatio		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in		,,,,,	
	3 Suicide 6 Could not be determined		ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route	Number,
Medical Certification:	29a. Certifier (Check only one) 1 Certifying Properties of the certifying Properties of the certifying Properties of the certifying Properties of the certified Propertie	nysician: To the best of my kni miner: On the basis of examina and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and plac ion, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as	s stated. e to the car	Jse(s)
Σ	29b. Signature and title of certifier	N	10	29c. License number D 560 €	1	Pate signed (Mont	Marie .	ar)
1	30. Name and address of person who	completed cause of death (Itee	n 23a) (Tyne Print)					

STIMP ASSOCIATES, HOLYWOOD

State Registrar

31. Date filed (Month, Day, Year) 32. Register's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygienes 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Month Mary Agnes Young Turner September 1, 2005 11:22 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 XF Yrs. Director 579-12-8015 89 Sept. 16,1915 Arkansas Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo St. Mary's Marvland California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ö or items 23a 23243 White Birch Court Completed by Funeral 20619 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. fited within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "t Elementary/Secondary (0-12) College (1-4or 5+) 4 Administrator Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Russell Young Agnes Donaldson Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 si ment of Health an ant: if Item 27 is r Thomas Turner/Son 25813 Whisker Creek Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of important: If It any injury or o 1 StBurial 2 Cremation 3 Removal from State Arlington National 9-16-2005 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun rail Service Lines see 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle Simons 22955 Hollywood Road, Leonardtown, MD 20650 M01206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sucfras cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Inset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) our /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) the attending physicien Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performed? (es 2 2 No 1□ Yes Director: After this certific tin by the funeral director. 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 5 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funersi Dire filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) dertifier 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) MO of death (Item 23) (Type, Print) 30. Name and addres of person who completed James P. 24035 Three Notch Road, Hollywood, Maryland 20636 yarboe, 31. Date filed (Month, Day, Year) State 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month THOMPSON **Physician** 4:40 PM CHARLES ROBERT 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PREDERICK NORTH HAMPTON MANOR REDERICR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year 12 M 2□F 214-54-0017 57 Yrs TUNE Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show other traumatic event, it is Medical Examiner must be notified at FREDERICR Yes 2 □ No MD FREDERICK Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Itams 23a or DRIVE GREENWAY U-5. A. 191 21702 death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK Specify: Be Completed by 3 Widowed 4 Divorced 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry SHOL REPAIR al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be if Health and Mental TETOMPSON BALL MAE FERGUSON OSBORNE LEROY 19b. Mailing Address (Street and Number or Rural_Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FREDERICA Md. 21701 Sonl 191 Green Way Drive EWYN O. Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place)

REST HOVEN (Com. Gover, Aug. 30, 2005 FRD), MS. 20c. Location - City or Town, State 20a. Method of Disposition ö Burial 2 Cremation 3 Removal from State = 5 permit. Page Department of Importent: If any injury or 4 □ Donation 5 □ Other (Specify) Early Louist South St Flooberer me 21. Signature of Funeral Service Licensee fecoberen mo Approximate Interval Between Onset and Death 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner inding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 2 No 1 Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending To the Funeral Director: After death.

To the Funeral Director: After the funeral by the funeral 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D58391 30. Name and address of err on who completed cause of death (Item 23a) (Type, Print) house Ave, Frederich, MD 32. Registrants Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene 2005 29399 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Mary Alice Troxell AUGUST 29, 2005 3:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Nov 26, 1912 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 214-09-8983 1 □ M 2 🔀 F 92 Yrs Director ΜĎ Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Neuloul Exterior and must be modified at MD Washington Hagerstown, 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1183 Luther Drive 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Ital 1 Never Married 2 Married Specify.white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry residence Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Õ 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bruce Deeds Alice Lydia Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 Is I Marianne Hawbaker daughter 325 Pangborn Blvd. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Paul Cemetery 20a. Method of Disposition Sept . 1, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Clear Spring MD ŏ permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licensee MUCKE P.O.BOX 310 Clear Spring, MD 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician erebro voscular accident DIVS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmisclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The to for as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Jursing Home 5 Residence 6 Other (Specify) 0 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation death Diractor: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To tha tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lo D28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAR 368 Hagerstown AR mille 31. Date filed (Month 32. Registrar's Signature State Registrar

Mary Alice

TROXELL,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 29400 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Yee err 0924 08 2005 23 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Medical Baltimore Mercy Center If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Y Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 1 M 2□ F Yrs Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No 10e. Street end Numbe 10g. Citizen of Whet Country? 10f. Zip Code 5 0 Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Merried 2 ☐ Married 1□ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IMEE CAROLYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) noll MEYER RD BAHOMD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 8/30/05 Woodlawn, Maryland Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) prematurit Due to (or as a consequence of): abo Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings 24a. Wes an autopsy performed? available prior to completion of cause of death? 1 ☐ Yes 2 🔀 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Director

Funeral

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Completed

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Peges 1 and 2 should be filed within 72 hours after death with the Marylend nent of Haaith and Mantel Hygiana. Int: If item 27 is marked other than "natural", or items 23s or 28s-f show

Saltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Madical Examinar must be notitled at

Depertment of Haatth and Mantel Hygis important: If item 27 is marked other any injury or other traumatic event, the page.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

Physician/Medical Examiner attending physician end for usa as tha bunal-transit tor: After this certificate has been signed by the the funerel director, page 2 should be detached ģ Completed After this certificate has been B 2 Certification:

The law requires that the death certificate be axecuted

or Attending Physician:

Director:

To the Hospital of within 24 hours are To the Funeral D

completely filled in by

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29a, Certifier

31. Dete filed (Month),

Division of Vital Records, P.O. Box 68760.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth

1 Neturel 2 ☐ Accident 5 Pending investigation 3 Suicide 4 Homicide

6 Could not be

Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

28c. Injury at Work? Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗌 Yes

29c. License number

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of artifi

Day, Year)

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature

State Registrar

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	- Funeral		Social Security Number 6.	Sex 1□M 2/XF	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Year)	9. Bir	thplace (State ountry)	or Foreign
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Maryland 21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itema 23a or 28a-f ahow na Madical Esantinar must be notified at	Completed	15. Decedent's (Specify only highest g		1	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most	t of workir	ng	16b. Kind	d of Business	/Industry	
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<u>Ч</u>	law requires that the de as been signed by the a 2 should be detached		9 ☐ Unknown Part II. Other significant conditions			sulting in the u	nderlying cause or	ven in Part I		23a Did to	hacco use	contribute to	o the cause of o	ieath?
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Division	al or Attending Physician: after death. I Diractor: After this certific d in by the funeral director,	ifica	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Ptac	of Injury - At h	ome, farm, str	eet, factory, office			8f. Location (S		Number or Ri	ural Route Num	ber,
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	6		30. Name and address of person who	o completed cau		alla		2000	4.1.	ele n	= /21	21716		
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	Registr	ar	AUG 2 (5 2005	College.	St.	GOBACU							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 200^{Yea} 6:35P Wilson, August 19, Edward Т. Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours | Min. | Sept. | 12, 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1935 Washington, 69 577-46-0855 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural; or itams 23a or 28a-f show any Injury or other traumatic event, the Medical Evantier must be required at once. 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 1X Yes 2 □ No Maryland Prince George Director Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4410 68th Place Apt. A-5 20784 United States 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1⊠Yes 2□No 1958 -1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Nidowed 4 Divorced 1960 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Employee Relations Specialist 12 4 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Maggie Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward T. Wilson, Jr. 4410 68th Place, Apt. A-5; Landover Hills, Md. 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. Aug. 26, 2005 Suitland, MD. ' 4 □ Donation 5 □ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 21. Signature of Funeral Service License 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BLEEDING DINITES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the attending physician ARRHYTHMIA by Physician/Medicai IF FEMALE: f yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 m onths?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conflibute to the cause of death? 3 Probably 4 Unknown Completed 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes 25. Was case referred of medical examiner? 26. Place of Death (Check only one) Certification: To Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a To the Funeral D 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m D50855 08-21-2005 Avenu a RROII lakoma Registrar's Signature State 2 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 2005 29403 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0130 2005 Beatrice Wimbush /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 longes Hospita Cheverle eorge 5 If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Nov. 8, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 M 2 F Yrs. North Carolina 240-58-4145 67 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County in then "naturel", or Items 23a or 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☐ No Prince George's Cheverly Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 United States 1610 Marble Wood Ave. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Housewife 12th and Mental Hygins Is marked other 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Importent: If Item 27 is marked oth any lijury or other treumatic event 20x8. Be Annie Mae Clarke Roy Vinson 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1610 Marble Wood Ave., Cheverly, MD William H. Wimbush / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee's Crematory 8/25/2005 Clinton, MD ` 4 ☐ Qonation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 8 4001 Benning Rd., N.E. Wash., DC 20019 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Pari1 Enter the disease, or complications that caused the or heart failure. List only one cause on each line. Immedi e ause (Final disease ondition Atheroschestic Cardiovasculor Heart **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to minimize cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1. Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗋 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALVADON Sylvestu 3001 100 31. Date filed (Month, Day, Year) State AUG 2 4 2005 Registrar

			1 - For State Registrar	State of Ma	ryland / De <i>C</i>	partment ertificate	t of H e of L	ealth an Death	d Mental	Hygien		5	29404
Ţ	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of		ay	Year	3. Time of Death
	/Medi		DOROTHY ALICE		E				AUGUS'		2005		9:05 AM
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* Æ	(a)		CARROLL HOSPITAL 5. Social Security Number 6. Secu		(In yrs. last birthda			NSTER If Under 24	Hrs. 8. Date o	of Rieth	CARRO		(6)
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	anylar show	7	10a. State 10b. County	_	10c. City, Town or							10	Od. Inside City Limits
	the M	ecto	MARYLAND CARROLI 10a. Street and Number	Ь	FINKSB								1∐Yes 2XXXVo
	with E or	Dir	2500 KAYS MILL ROA	D		10f. Zip	2104	8			itizen of Wi ITED		•
	be filed within 72 hours after death with the Maryland that Hygiene. So other then "naturel", or Items 23s or 28a-f show event, I're Modical Examinar must be notified at	Funeral Director		12. Was Decedent E	ver in U.S.	3. Was Deced	ent of His	spanic Origin	? (Specify Yes o	r No-	14. Race		
9	or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes →2 F No If Yes, Give		If Yes, spec	ify Cubar	n, Mexican, P	uerto Rican, etc.	.)	Black	, White, e	etc.
8	iours,	d by	₩Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2	ALANO	Specify:			Specify:	WHI	TE
Maryland 21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Gi	edent's Usua ve kind of wor	k done d	luring most of	working	16b. I	Kind of Bus	iness/Ind	ustry
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9	e filed within al Hygiene. i other then '	Be Co	17. Father's Name (First, Middle, Last)			HOTHER		18. Mother's	Name (First, Mid				
lan	should be nd Mental marked o matic eve	To B	HERBERT HENRY BR	NWC				MAR	Y ELIZAE	BETH H	ENDER	SHOT	,
ary	shou s ma	_	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	iling Address	(Street a		r Rural Route No				
	and 2 ealth n 27 I		RANDY WAREHIME, SR	/SON				L ROAD	, FINKSE	BURG,	MD	2104	.8
ore	ges 1 of Ha if iter		20a. Method of Disposition XXBurial 2 Cremation 3 R	emoval from State	20b. Place of Dis	position (Nam ematory or ot	e of her place	9)	Date		ocation - C	-	
Ë	. Рад tment tent:	l v	`4 □Donation 5 □Other (Specify)		SANDYMOU	NT U.M.	. CE	METERY	8/27/2	2005	FINKS	BURG	, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic ex anges.		21. Signature of Funeral Service License	-1-		22. Name and MYFRS-I			UNERAL H	OME.	РΑ		
			23a. Par 1. Enter the disease, or compli	nations that naused to								157	
Ь	200		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line).	inter the mode	or dying	, such as can	diac or respirato	ry arrest,			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		consequence of):	JAIL		HEM	OBBH	3 2A		_	OBYS
	Examiner					9						1	
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ő	e exe ian a urial-1		resulting in death) Last	Due to (or as a	consequence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	dlcal	d										
9	that the death certificed by the attending properties as	0	IF FEMALE:	3c. If yes, outcome of	foregnancy		-						
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5	w require been sig should b		ATRIPL	F130	SICCAT!	401			_ 1	☐ Yes 2	□ No 3	☐ Proba	bly 4 Hunknown
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<u> </u>		Com							P	utopsy erformed? s 2 No	o dea	ath? Yes 2	
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Division of	ding Phy h. After thi funeral	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury		C. Injury	?	28d. Descri	be how inju	гу оссиггес		
<u>S</u>	or Attendi utter death Director: # in by the fi	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Płace of Injury	v - At home farm s	M tract factors		es 2□No	28f Locatio	n (Stroot as	od Numbor	or Perrol	Route Number.
<u>S</u>	after Dire	ertii	4 ☐ Homicide determined	building, etc.	(Specify)	rieer, ractory,	OHICO			Town, State		or Murai i	Houte Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificacompletely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, dea	ith occurred at	t the time	e, date and pl	ace, and due to t	the cause(s	and mann	er as stat	ted.
	n 24 he Fu	edical	(Check only 2 Medical Examin	nar: On the basis of e and manner state	xamination and/or	nvestigation, i	in my opi	nion, death o	ccurred at the tin	ne, date and	d place, and	d due to ti	he cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier				License			29d. Da	te signed (Month, Da	ay, Year)
	1015		KO	ila		D	005	19225	>	8	241	05	
	W-3		30. Name and address of person who cor		ath (Item 23a) (Type	, Print)				-	•		
			NIBHA KOHLI M.D. 31. Date filed (Month, Day, Year)	686C PO 32. Registrar	OLE ROAD	WESTW	IINSI	ER, M	21157				
	Sta Registr	-	AUG 2 5 2	2005 Siles	s signature	1-1	•						
					-	AND AND ALL	1						

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, it is Modical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

	1 - For State Registrar		State	n warytar		rtificate of		wentai Hyg	lene a N	2005	29405)
	1. Decedent's Name	e (First, Midd	lle, Last)					2. Date of Dea			3. Time of Death	-
an al	Wilma	Jean	Wolfe					Month August	21,	200		
er	4a. Facility Name (I	f not institutio	n, give street and nu	mber)		4b. City, Town,	or Location of Deal	th	4c.	County of De	ath	_
			nor Healt				erick			Frede		_
	5. Social Security N 234-32-3		6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 81	last birthday) Yrs.	Months Days			Year) 1923	9. Bi	rthplace (State or Foreign Country) t Virginia)
	Usual Residence of											-
tor	Maryland	10b. County Fre	derick	10c. Cit	ty, Town or Lo		ederick				10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
irec	10e. Street and Nur	mber				10f. Zip Code		1	0g. Citiz	en of What C	country?	_
ralD	200 East	16th	Street				21701			ted St	· ·	
nue	11. Marital Status	nd OF Mar	Armed Fo		.S. 13. V	Was Decedent of Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	1	4. Race - Am Black, Wh	erican Indian, ite, etc.	
Be Compieted by Funeral Director	3 Widowed		If Van Ci	/e **	,	l□Yes 2[X]No	Specify:			Specify:	White	
ietec		ify only highe	nt's Education est grade completed)		16a. Deced	lent's Usual Occu kind of work done	pation during most of wo	rking	16b. Kin	d of Business	s/Industry	_
Somp	Elementary/Second 12	ndary (0-12)	College (1-4or 5+)		ninist				Optic	al	
To Be (17. Father's Name (•				18. Mother's Nai Delta T	me <i>(First, Middl</i> e, <i>I</i> Cal1man	Maiden S	Sumame)		
	19a. Informant's Na Connie E		ship <i>(Type, Print)</i> perger / d	aughter	19b. Mailin 2 Aı	g Address (Stree	and Number or Ri Middlet	own, MD	City or 2176	Town, State,	Zip Code)	
	20a. Method of Disp 1 Burial 2 ['4 Donation	Cremation	3 □Removal from Specify) Entomb	State	emetery, crem	sition (Name of natory or other pla	1	Date :		ation - City or	Town, State	-
	21. Signature of Fu	neral Service	Licensee	ment M	22	Name and Addre		Stauffer				-
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			complications that of only one cause of						est,		Approximate Interval Between	-
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mpieted by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live b	come of pregna irth 2 🗆 Fetal ant at time of de own	death 3	Ectopic pregnanc Other (specify) _	У		23	8d. Date of de Month	livery Day Year	
d by Pr	CERR	BRAL	ons contributing to de	AR D	158A		ren in Part I.		acco us		o the cause of death?	
mpiete	MULT	1-INP	Aret C	AM AN	TIA			24a. Was ar autopsy			utopsy findings available completion of cause of	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician /Medical

Be Completed by Physician/Medical Examiner nerel Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached Medical Certification: To within 24 hours after death. To the Funerel Director: After

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 - Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

Other:

28d. Describe how injury occurred

4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certification

026499

29d. Date signed (Month, Day, Year)

2 🗆 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

State Registrar

			For State Registrer	State of	Marylan			t of Heal e <i>of Dea</i>		Mental Hy	gienę Reg. Nd.		29	406
	Physicia		1. Decedent's Name (First, Middle, Las Dorothy M. Wolfe	1)						2. Date of De Month August	ath Day 20	Yea 2005		of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and num	nber)		4b. City,	Town, or Loca	ation of Death			County of De		IOA
			Citizens Nursing H					ederic					erick	
	Funeral Director		5. Social Security Number 6. Se 10 233-40-4176	x □M 2QTF	7. Age <i>(In yr</i> s 83	last birthday) Yrs.	Months Months		ours Min.	8. Date of Bird (Month, Da Jan 19	y, Year)	9. B	Birthplace (Stat Country) Indsvil	
			Usual Residence of Decedent							Jan 17	172	2 1100		
	show	J.	MD Frede	rick	10c. City	y, Town or Lo Thurmo								City Limits es 2 ☐ No
	28a-f	Director	10e. Street and Number	TICK			10f. Zip	Code			10g. Citi	zen of What	Country?	
7	3a or		6544 Mountaindale	Road				21788				USA		
2	tiled within 72 hours aller beath with the maryland Hygiene. Inther than "natural", or Items 23a or 28a-f show ent, the Modical Examiner right be recitified at	y Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For 1 Tes If Yes, Giv	2 <mark>Т</mark> Nо ө	1	Was Dece f Yes, spe 1 ☐ Yes		ic Origin? (S exican, Puert ecify:	pecify Yes or No o Rican, etc.)	-	14. Race - Ar Black, Wi Specify:	merican Indian hite, etc. White	•
5 .	"natural",	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Ed	Year or Da	ıtes:	16a. Dece	dent's Usu	al Occupation			16b. Ki	nd of Busines	ss/Industry	
2	be filed within 72 ng tal Hygiene. d other than "natuevent, It e Madical	Completed	(Specify only highest grade		-4or 5+)	(Give	kind of wo DO NOT u	rk done during se retired)	most of wor	king			,	
	ygiene gertha	Com	12	- College (1			Labo						Glass F	actory
3	o d la b	Be	17. Father's Name (First, Middle, Last) Hillary Jube Coll	mer						ne <i>(First, Middl</i> e, ma Ryan	Maiden	Sumame)		
3	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or othar traumatic. <u>once.</u>	은	19a. Informant's Name/Relationship (7			19b. Mailir	ng Address			iral Route Numbe	er, City o	r Town, State	a, Zip Code)	-
2	and 2 s ealth an m 27 Is nar trau		Dwight E. Wolfe,				•			d, Thur				
	es 1 a of Hea fitem rotha		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from	20b. P	lace of Dispo	sition (Na natory or	ne of other place)		Date	20c. Lo	cation - City	or Town, State	
	Pages ment of I tant: If its jury or o		`4 □Domation 5 □ Other (Specify		Hag			emator		/05	Hage	erstow	n, MD	
2	permit Depart Import any in once.		21. Signature of Furieral Service Liber	50 Mill	came	J	ohn I	Address of Will	iams F	uneral H	lome			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on e	aused the deat ach line.	h. Do not ent	00 Pe	tersvi Je of dying, su	11e Ro ch as cardiad	ad, Brun or respiratory a	nswid rrest,	ck, MD	21716 Approxim Interval I Onset ar	Between
Ť	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ntia,		nced	Alzhe	eimer	S			3 yea	ars
ı	Examiner				etes	001100 01).							20 y	ears
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq	uence of):	-						0	
	icate be executed physician and sthe burial-transit	Examiner	that initiated events resulting in death) Last	c. CHF	or as a conseq	uence of):							2 yea	ars
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0	tificate ig phy as the	a a		U										
. DOY	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 brous after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩0 9 ☐ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3[Ectopic p Other (s					23d. Date of o Month	delivery Day	Year
	uires that the de isigned by the a ld be detached f		Part II. Dther significant conditions of	ontributing to de	eath but not res	ulting in the u	nderlying	ause given in	Part I.	23e. Did t	obacco u	se contribute	to the cause	of death?
200	quires n sign uld be	ed by								1 🗆 '	Yes 2	□No 3□	Probably 4	Unknown
משט	sıcıan: The law requir. s certificate has been si lirector, page 2 should l	Completed					·			24a. Was auto perfo		prior t death	autopsy findin to completion o ? es 2 No	
2	cran: ertifica actor,	Be	25. Was case referred to medical examiner?	t la animali	-			044	-	ath (Check only o				
5	Physi this c ral dire	-T	1 ☐ Yes 2 ♠ No 27. Manner of Death	Hospital: 1 🔲 I		ER/Outpatier 28b. Time o		OA Other: 4 28c. Injury at	Nursing H	lome 5 Resi			pecily)	
5	ding th. : After fune	tion	1 Matural 5 Pending 2 Accident investigation	(Mont	h, Day Year)	Injury	м	Work? 1 ☐ Yes	2 🗌 No		,			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place	of Injury - At h		reet, factor	y, office		28f. Location (. City or To	Street an wn, State	d Number or)	Rural Route N	lumber,
	ne Hospit n 24 hours ne Funera stetely fille	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exem	niner: On the ba	best of my kno asis of examina ner stated.	owledge, deat ition and/or in	h occurred vestigation	at the time, d	ate and place n, death occu	e, and due to the urred at the time,	date and	place, and c	lue to the caus	
	To t To tl	Σ	29b. Signature and title of certifier				2 <u>9</u>	0.46248	mber		29d. Da	te signed (M^{0}	onth, Day, Year 5	r)
	5		30. Name and address of person tho	completed caus	e of death (Iter	п 23а) (Туре,	Print)	-	1 .	1 1/0				
	9								deric	ck, MD	21	/01		
	Sta Registi		31. Date filed (Month, Day, Year) AUG 2	5 2005	egistr s Signa	ature &	Ap	and a						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Williams /Medical 7 05 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number Maryland 6. Ser Butture der 1 Year If Under 2 Medical Center 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F Months Days Hours Min 159-28-6364 Director 75 Mar.23,1930 Pennsylvania Usual Residence of Decedent with the Maryland ahow 10a, State 10c. City, Town or Location 10b. County ir than "natural", or Items 23a or 28a-f ahov The Medical Evantings must be notified at 10d. Inside City Limits 1 Yes 2 □ No Maryland Dorchester Direct Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Delaware Ave., Funeral apt.23 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Widowed 4 Divorced natural Specify: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygit Important; if item 27 is marked othar any injury or other traumatic appart. Home Maker Private Families 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Cottom Corrine Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hill / Son 6313 Palmers Mill Raod, Hurlock, Maryland 21643 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State '4 □Donation 5 □ Other (Specify) Washington Cem. 9/2/2005 Hurlock, MD Page 22. Name and Address of Facility
Bennie Smith Funeral Home
516 S. Maine Street, Hurlock, Maryland 21643 21. Signature of Fine ral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Depsis Wedical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entailing, cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, the attending physician use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death Dav 5 Other (specify) 9 Unknow been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy ormed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification; To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c, Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. after death.

Diractor: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner etated. 29a. Certifier Medical (Check only one) nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15809 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) Belin Greene Street Balto, MD 22 South AUG 3 0 2005 31. Date filed (Month, Day, Year, State Registrar

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** august 0717AM June Lorraine Wright 2005 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗗 F 219-36-3265 67 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notitied at 1 ☐ Yes 2 ☐ No Hagerstown Maryland Washington Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 116 W. North Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 Never Married 2 Married 1 ☐ Yes 📆 No Specify: Black Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natu any injury or othar traumatic evant, The Medical once. 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hairstylist Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Cleo Brooks James Overton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1105 Lindsay Dr. Hagerstown Md 21742 Kelvin Wright/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | Sept 7 2005 Hagerstown MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service License 1601 Pennsylvania Ave Hagerstwn MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3-hwy grennana Physician /Medical Due to (or as a consequence of). Examiner Pancres with Carcinona Sequentially list conditions, Due to (or as a consequence of): rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) the 9 Unknown detached 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed 2 Palmen 1 Yes 2 No 3 Probably 4 Unknown obetuchia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dynphosis has autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 No 1 ☐ Yes certificate or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this Diractor: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P1081 G AVG 30, 2005 - COM MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAGERSTOWN, MO: 21740 VASANT MILLST DATTH MO 340 5H-1 AUG 3 1 2005 32. Registrar's Signature 31. Date filed (Month, State Specker Registrar

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 29409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** MARTHA LOU WHISNER 14.00 PM AUG 28 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore, r St Agnes
5. Social Security Number mb 8. Date of Birth (Month, Day, Year) Jan. 25,1948 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☑ F 57 Yrs. 224-58-3572 Director West Virginia Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits •how rthan "natural", or items 23a or 28e-f ehov the Madical Examiner must be notitied at WV Jefferson Charles Town MXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 273 Beauregard Blvd. 25414 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 20 No Specify: White ģ Specify: 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) Retail Pharmarcy Store Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I Alonza S. Welch Katherine L. Fritts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and Item 27 le r Hope E. Thompson/Sister 273 Beauregard Blvd., Charles Town,WV 25414 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Ite
eny injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Nebo Cemetery 8/31/05 Great Cacapon, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Ptr/. Enter the disease or complications it is caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RESPIRATORY Physician week disease or condition resulting in death) /Medical Due to (or as a consequence of): HYPOVENTILATION SYNDROME Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of). Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ■ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, PREUDOMONAS-PAEUMONIA. 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death |Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣ No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident al or Attence after death | Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 29c. License number A 5-52438528 AUG, 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 - South Baltimore MD, NSH-4 21229 Catons Avenue, 31. Date filed (Month, Day, Year) AUG 3 0 2005 State Registrar

		1 - For State Registrar	State of Maryla		artment of F tificate of			gien 2 0 0 5	29410
-17	ician dical	1. Decedent's Name (First, Middle, La	Wishard	I,sR.			2. Date of Dea Month Augus	4 23 200	
Exar Funer Direct		4a. Facility Name (Phot institution, gin Univelsity of 5. Social Security Number 219-66-0766	Mayland Medi	ical (QUI s. last birthday) Yrs.	4b. City, Town, of Ball If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	_	y, Year) C	
ie Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County Washin		City, Town or Lo			•		10d. Inside City Limits
21215-0036 If within 72 hours after death with the Maryland piece. Than "natural", or items 23e on 28e-f show the Medical Examiner must be notified at	Funeral Dire	10e. Street and Number 520 Wilson Blv 11. Marital Status	12. Was Decedent Ever in Armed Forces?		10f. Zip Code 217 Was Decedent of H	40 Hispanic Origin? (San, Mexican, Puer	pecify Yes or No	10g. Citizen of What C	erican Indian,
21215-0036 Id within 72 hours after glene. er than "natural", or it, the Medical Examins	ted by Fu	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates:	16a, Dece	1 ☐ Yes 2 ☑ No	Specify:			white
44 000 -	0	(Specify only highest girll Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	College (1-4or 5+)	life.	DO NOT use retire	e Assist	ant	Funeral 1	Home
aryla should and Men is marka	ToB	Donald Eugene W. 19a. Informant's Name/Relationship	(Туре, Print)			and Number or Re	ural Route Numbe	rmentrout er, City or Town, State,	
imore, Pages 1 an nent of Heel ant: if itam 2		Karen Lee May 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	20b. □Removal from State	Place of Dispo cemetery, crei		сө)	Date	rstown Mar 20c. Location - City o Hagerstown	
Baltimore permit. Pag Department Important: any Injury of	- SUCE	21. Signature of Funeral Service Lice	Lury	13		ess of Facility Do	ouglas A N. Haye	. Fiery Fur	
Physicia /Medic Examin	al	shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	D	ssection				Interval Between Onset and Death
ficate be executed physician and sthe burial-transit	Je Je	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse					008(0200 216)	
Records, P.O. Box 68 The law requires that the death certifics the has been signed by the attending pl age 2 should be detached for use as t	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnanc	у		23d. Date of de Month	olivery Day Y <i>e</i> ar
cords, P. w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause gn	ven in Part I.		obacco use contribute (o the cause of death?
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ivision of or Attanding Phy ter death. iractor: After this oby the funeral d	rtification: To B	examiner? 1 Yes 2 No 27. Mann of Death 1 latural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not 4 Homicide determined	28a. Date of Injury (Month, Day Year)	home, farm, str	28c. Injui Wo	ner: 4 ☐ Nursing H	A cute	dence 6 Other (Sp. now injury occurred Sfontanto Street and Number or F	us Artiz
Hospital 4 hours a	Medical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	n occurred at the ti- vestigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the I within 2 To the I complet	W	29b. Signature and title of certifier	MD,	am 22a) /Ta-	29c. Licens 063	3 454		29g Date signed (Mon 4y-23-	th, Day, Year)
	State istrar	30. Name and address of person who university of A 31. Date filed (Month, Day, Year) AUG 29	lary land Me	dical c	ente,	Divisin	of Casa	luic surg.	2005 Vy, 22 5.5(cm strut Raltimore, M

Ğ			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	epartment of Hea Certificate of De	ilth and Mental	Hygier	ne 2005	29411
			1. Decedent's Name (First, Middle, Las	st)			2. Date Monti		Day V	3. Time of Death
	Physici /Medio		Jack Donald	Ammann				tembe	Day Year 2005	10:13 A ^M
}	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Loc		4	4c. County of Death	
			7070 Cradle Rock			Columbia			Howard	
	Funeral		5. Social Security Number 6. S	ex 7.Ag ☑M 2□F	e (In yrs. last birtho 75 Yrs	Months Days He	Under 24 Hrs. 8. Date of Mont	of Birth h. Day, Yea	9. Birthp Cour 1930 Per	place (State or Foreign ntry)
	Director		194-22-0521 Usual Residence of Decedent		75		Marc	511 50	, 1930 Per	nnsylvania
	yland		10a. State 10b. County		10c. City, Town o	r Location			1	0d. Inside City Limits
	e-f	ctor	MD Howard		Columb	ia				1 ☑ Yes 2 ☐ No
	or 28	Olre	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Cour	ntry?
	ath w	rai	7070 Cradle Rock	Y		210			USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menial Hygiene. It has the marked other then "neturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:		13. Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🖾 No Sp	nic Origin? (Specify Yes of lexican, Puerto Rican, etc pecify:	or No- c.)	14. Race - Americ Black, White, Specify: Whi	etc.
5	72 h	etec	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(0	ecedent's Usual Occupation live kind of work done during	n og most of working	16b.	. Kind of Business/In	dustry
121	within ene. then "	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5	5+)	de. DO NOT use retired) alesman			Food Brok	rer
	filed withi Hygiene other ther		17. Father's Name (First, Middle, Last)	P			Mother's Name (First, M	iddle. Maid		
Maryland	ould be Mental Marked o	To Be	Edward John Am	mann			Margie Ma		S (5)	
ary	2 should and Menis marke	-	19a. Informant's Name/Relationship (Type, Print)	19b. N	lailing Address (Street and I				Code)
Σ	1 and 2 Health a tem 27 is		Darlene Oliver/Da	ughter	550	Munroe Circ	le, Glen Bur	cnie,	MD 21061	٤
ore	ges 1 au t of Hea tf item or othe		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State	20b. Place of D cemetery,	sposition (Name of crematory or other place)	Date	20c.	Location - City or To	own, State
Ë	Pag ment ant: f		4 Donation 5 Other (Specify		West Ar	undel Crem.	9/12/2005	-	denton, MI	
Baltimore,	permit. Pages 1 Department of P Important: if ite any injury or ot ance.		21. Signature of Funeral Service Licer	0 1/	101103	22. Name and Address of 313 Talbott				
н			23a. Part 1. Enter the disease, or com shock or heart failure. List only							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hypert	ensive Ar	teriosclerot	ic Cardiovas	scular	Disease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)					
		-	Sequentially list conditions, any, leading to immediate	b. Due to for as	a nonsequance of)					
	uted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	•	,					
່ດໍ	icate be executed physicien end s the burial-transit		resulting in death) Last	Due to (or as	a consequence of)					
68760,	ite be iysicié he bu	edicai		d						
			IF FEMALE:							
P.O. Box	The law requires that the death certifi site has been signed by the ettending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		_	23d. Date of delive Month	ery Day Year
	res that igned to be deta	by P	Part II. Other significant conditions of	ontributing to death b	ut not resulting in th	e underlying cause given in	Part I. 23e.	Did tobacc	o use contribute to the	ne cause of death?
rds	w require been sig should b							1 🗌 Yes	2 No 3 Prob	ably 4 🖄 Unknown
of Vital Records,	law requ as been 2 shoul	Completed						Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u> </u>		Com					101	performed?	? death?	2 ⊠ No
/ita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11			Place of Death Check of	only one)		
of 0	Physi this c	5	1XX es 2 □ No 27. Manner of Death		ent 2 ER/Outpa		Nursing Home 5			at scene
	ding After fune	tlon	1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Ye <i>ar)</i> 28b. Tim y Ye <i>ar)</i> Inju			ribe now in	ijury occurred	
Division	l or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be		ury - At home, farm	, street, factory, office		ion (Street	and Number or Rura	l Route Number.
Ö	after s after i Dire	Certification:	4 Homicide determined	building, et	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		r Town, Sta		
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best niner: On the basis of and manner sta	examination and/o	eath occurred at the time, do	late and place, and due to n, death occurred at the t	the cause time, date a	o(s) and manner as si and place, and due to	lated. the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier			29c. License nur	mber	29d. [Date signed (Month,	Day, Year)
	*) N	VI. //		O.C.M	.E.	Se	eptember 8	3, 2005
	20		30. Name and address of person who							
	σ		JACKM,	TIN MI		111 Penn St	reet, Baltin	nore,	Maryland	21201
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	Rigall B				
	i iogioti		SEP 0 9 3	UUD Jee	me de	Market Street				

		1- State of Maryland / Department of Health and N Certificate of Death	Mental Hygier	
Physic		1. Decedent's Name (First, Middle, Last) JoAnn Anderson	2. Date of Death	Day Year 3. Time of Death 3:14 (AM)
/Medi Examil		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Sinal Hospital of Baltimore Baltimore		4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
tryland	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
036 ours after death with the Marylan purs after con 230 or 280-1 show EXECUTER must be notified at	Funeral Director	MD NA Baltimore 10e. Street and Number 10f. Zip Code	10g. (1 ≥ Yes 2 □ No Citizen of What Country?
death wi	nerai [43 05 Ridgewood Avenue 21215 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - American Indian,
5-0036 72 hours after netural; or its	by	1 □ Never Married 2 Married 1 □ Yes 2 Mono If Yes, Give Year or Dates:	nicari, etc.)	Black, White, etc. Specify: Black
O T = =	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ang	Atlas Institute)
and 212	Be		e (First, Middle, Maid	len Sumame)
Maryland 2 d 2 should be filed th and Mental Hygis 77 is marked other treumatic event, II	T _O	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rur	le Ander	
S, N		comptent crematons or other place)		MV 2121S Location - City or Town, State
timo t. Page timent creent: If		4 Donation 5 Other (Specify) Gamson Forest D9.		wings Mills iMD
Bal permi Depar impor any ir	a l	Vaugh C. Greené Fur SISI Baito. Nati Pike	BUTTO MU Z	1007
Physician		23a. Part1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence of):		
cuted and ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
68760, 6 ificate be executed g physician and as the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of): d.		
Box 68 Box lostifica eath certifica attending pt	an/Med	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
P.O. B nat the dea d by the att	Physician/Me	in the past 12 months? 1		Month Day Year
rds, F quires tha en signed uld be de	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Non Small Cell Lung Carcinoma	23e. Did tobacci 1 ☐ Yes	o use contribute to the cause of death? 2 No 3 Probably 4 Munknown
Reco he lawre e has bee	ompleted		24a. Was an autopsy performed?	
Vital Iclen: Ticlen: Ticlen: Dector, p	BeC	examiner / Hospital:	h (Check anly one)	No 1 □ Yes 2 No
ing Phys	ation; To	27. Manner of Death 1 Satural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	ome 5 Residence 28d. Describe how in	6 □Other (Specify) jury occurred
Division of Vital Records, P.O. Box 6 To the Hospitel or Attending Physicien: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certificat	2 Accident investigation M 1 Yes 2 No 3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Hospitel 4 hours 8 Funeral I	ledical Ce	29a. Certifier (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated	and due to the cause red at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier 29c. License number	29d. C	Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		eptember 2,2005
St	até	Adam J Carinci M.D. Sinai Ho 31. Date filed (Month, Day, Year) 32. Registrar's Signature	spital at	Daltimore
Regist	rar	SEP 0 9 2005 Alexander 15 100012		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 4c per doc 3847

State of Maryland / Department of Health and Mental Hygiene

		4	1- For State of Maryland / Department of Health and Merital Hygierie Certificate of Death Reg. No. 2 0 0 5 2 9	1413
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time	e of Death
,	/Medic	al	BCU LATI, BRINSER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	5.05 pm
	Examin	er	GOOD SAMARITAR HOSPITAL BALTIMORE, MD WISH.	,
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Stat	te or Foreign
	Director			AND
	and ow	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
	Mary I sh	ţ	MD BACTIMORE BACTIMORE	es 2 No
	th the	jrec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	ath wi	Funeral Director	8800 Old Hartond Kd. Apt 318 21239 USA 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian	
	tar de Itams	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc.	
920	hours after death with the Maryland turel', or Itams 23a or 28a-f show at Extendiner must be motified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	(.
21215-0036	72 hours "naturel", olcel Ex	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working	
121	.⊆ ∈ ₹	ldmo	Elementary/Secondary (0-12) College (1-4 or 5+) (lerk Waight Watc	hers
	Hyg Tha	Be Co		110. 5.
/lan	0 0 0 0	To B	(Unkhown) Jennett 110ra (Unkhown)	- 31/
Maryland	2 sho and l		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	11204.
	s 1 and 2 should f Health and Men flem 27 is marke other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of Dispositi	MU
nor	0° = 5		1 Burial 2 Cremation 3 Removal from State Note and Mark 19-9-05 BATT MORE M	0
Baltimore	orta		21. Signature of Funeral Service Licensee 22. Name and Address of Facility BALTI RORE	
8	Dep Imp		FUNLERLY G. DAVIOLETY EVANS FUNERAL CHAPEL, 8800 HARFORD	
			Onset a	Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Sep 5 (Due to (or as a consequence of):	
	Examiner		URINARY TON = 1415-3-1	
	p #	Iner	if any, leading to immediate Due to (or as a consequence of):	
V	be executed sician and burial-transit	Examlner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
68760,	The law requires that the death certificate be executed ate been signed by the attending physician and page 2 should be detached for use as the burial-transit			
687	ifficate ig physias the	ledical		
Вох	th cert tendin ir use	an/N	23b. Was decedent pregnant 1	Year
.O. E	es that the death cert igned by the attendin be detached for use	Physician/N	in the past 12 months? 1	
<u>α</u>	that the ed by detac			of death?
Records,	quires in sign uld be	ed by		□Unknown
000	aw requir as been si 2 should I	Completed	Pelmonae fibrose 24a. Was an autopsy prior to completion	ngs available of cause of
H.		Com	performed? death? 1 Yes 2 No 1 Yes 2 No	
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	
ō	Phye	1.70	1 Tes 2 No 1 Empatient 2 EMOurpatient 3 DOA 4 Nursing nome 5 Nesidence 6 Outlet (specify)	
ion	Attending F r death. sctor: After by the funera	atlor	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
Division	r Atterdering in by the	Certification;	2 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route In City or Town, State)	Vumber,
۵	pital c			
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caudine) and manner stated.	se(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29c. License number 29d. Date signed (Month, Day, Yea	
			MO DR MAN N-00 D 006233 9 SEPT. 6 20	5
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COOD SAMPMITAN HOSPITAN	
		ate	31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	

		for State Registrar	State o	f Maryland	/ Depa	rtment of h	lealth and	Mental Hyo	giene 2	005	201	. 11.
		Registrar 1. Decedent's Name (First, Middle, L	astl		Cer	tificate of	Death	2. Date of Dea	.og. 110.	000	294	
Physici	_	Gladys	2001/			Bro	ady	09 Month	06 ^{Day}	2005 2005	12:10	
/Medio Examir		4a. Facility Name (If not institution, g	live street and nu	mber)		4b. City, Town, o	r Location of Deat	h	4c. Cour	nty of Death	<u> </u>	-
		Joseph Richey				Baltim If Under 1 Year						
, Funeral Director		218-52-3253	.Sex 1□M X TXF	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.		/, Year)	Coun	ace (State or Fi ry) A	oreign
land w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation	*			10	d. Inside City L	imits
Mary Mary	tor	MD NA		Balt	imo	re					1 X]Yes 2	□No
or 28	Funeral Director	10e. Street and Number				10f. Zip Code			-	of What Coun	try?	
s 23s	ral	2235 Cloville		-d	10.1		1214	S		S · A ·	a ladia	
fter de	Fun	 Marital Status Never Married 2 Married 	Armed Fo		j		an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. B	lack, White,		
5-UU30 // // / / / / / / / / / / / / / / / /	þ	3 ☐ Widowed 4 🛣 Divorced	If Yes, Gir Year or D	ve		I □ Yes a No	Specify:		Spec	cify: Bla	ack	
natu	letec	15. Decedent's (Specify only highest of	Education grade completed)	1	(Give	lent's Usual Occup kind of work done OO NOT use retired	durina most of wo	rking	16b. Kind of	Business/Ind	ustry	
d Z I Z I filed within Hygiene. ither then "	Completed	Elementary/Secondary (0-12) 12th grade	College (ducator	1)		Col	llege		
a filed within all Hygiene.	Be C	17. Father's Name (First, Middle, La					18. Mother's Na	me (First, Middle,				
naryland 2 should be fill and Mental Hy is marked oth	2	Clarence Tayl						Tankar				
ife, INTAINING ZIZID-UUJO 1 and 2 should be filed within 72 hours after death with the Marylan (Health and Mental Hyglene. Item 27 is marked other then "natural", or Items 23c or 28e-1 show other treumatic event, the Medical Evantrial must be retilled at		19a. Informant's Name/Relationship				-		ural Route Numbe Baltimo	-		Code) L215	1
other tr		Cathy Murphy-s 20a. Method of Disposition	sister			sition (Name of natory or other place		Date		n - City or To		
Pages lent of nt: If i		1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				morial		9/05	Randa	allsto	own, M	d
BAILIMOR permit. Pages: Department of h Importent: If ite any injury or of		21. Sign tu spo Funeral Service Lic	censee	ionAt	22 M	Name and Addre	ss of Facility H West	e, Balt:	imore	, Md	21215	
4-		23a. Part1. Enter the disease, or co	omplications that	caused the death. [7	Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	., 5110 02000 511 0		aria	in Can	ncer				Onset and Dea	ath
/Medical Examiner		resulting in death)	Due to	(or as a consequen		-					Tours	
	er	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequen	ce of):							
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							+		
8 / 60, and are be executed hysician and the burial-transit		resulting in death) Last	Due to	(or as a consequen	ce of):							
p8 / bu	edical		d									
Certification ding	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnancy		_			23d. I	Date of delive	·v	
that the death of the detached for u	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		pirth 2 ☐ Fetal de nant at time of death nown		Ectopic pregnancy Other (specify)	<u></u>		1	Month	Ďay Yea	ır
OrdS, P.	by Ph	Part II. Other significant conditions	s contributing to d	leath but not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to th	e cause of deal	th?
COTOS w require been sig								1 🗀 Y	′es 2□No	3 ☐ Proba	ibiy 4 Donk	nown
fec e law has b	Completed							24a. Was autop perfor	med?	prior to con death?	sy findings ava apletion of caus	ulable se of
VITAL P. SICIEN: The certificate rector, pag	a)	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only o	2.2 No	1 🗆 Yes	2 No	
- X S D	To B	examiner? 1 Yes 2 No	Hospital: 1 🗆	Inpatient 2 ER	/Outpatier	t 3□ DOA Ott	ier: 4 ☐ Nursing I	Home 5 ☐ Resid	lence 6	Other (Specify	HOSP	ice
	lon:	27. Manner of Death 1 Natural 5 Pending		of Injury eth, Day Year)	b. Time of Injury	Wo	yat k? Yes 2 ∐No	28d. Describe h	low injury occ	curred		
ISIC tten deatl ctor: / the	ficat	2 Accident investigal 3 Suicide 6 Could no	t be 28e. Place	e of Injury - At home	, farm, str		165 2 140	28f. Location (S		mber or Rurai	Route Number	r,
i giệt c	Certification:	4 Homicide	build	ling, etc. (Specify)				City or Tow	n, State)			
Lo the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	caminer : On the b	e best of my knowle basis of examination iner stated.	dge, deat and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occ	e, and due to the ourrod at the time, o	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)	
To the within 2 To the complet	ž	29b. Signature and title of certifier	100			29c. Licens			_	ned (Month, L		
^		> 2 120N	N)			ν	4170		Septi	ember	6,200	5
,}			no completed cau	tospice	8a) (Type,	Print) EL	iteus st	- Balt	imere	MD	21201	
St Regist	ate trar	31. Date filed (Month Day Year)	2005	to spice		234						

Edward Bennett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-06085 Unpend Item 23a, 27, 28a T per me 382, 15 05 Las Mental Hygiene 2005 crn Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Bennet September 05, 2005 9:53 Edward /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 5 N. Highland Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5. Social Security Number 104 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 154M 2□ F Yrs. May 17, 1979 Baltimore, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County •how The Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Carrol Directo WD Hampstead 28a-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ States 21074 Snited 238 Road 5282 Funeral Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 5 Baltimore, Maryland 21215-0036 1 □ Yes 25 No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other then treumatic event, the Mi Elementary/Secondary (0-12) College (1-4or 5+) arpenter 12 raming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Dabrowsk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tree Hampstead, Mary land 20c. Location - City or Town, State 5282 Wer Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition rtment of 1 1 Burial 2 Cremation 3 Removal from State Important: If eny injury o once. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Oaklawn Cemetery 21. Signature of Funeral Service Ligar see 22. Name and Address of Famility BACT MORE, MD 21231. aurothe univers 6 EVANSFUNERAL CHAPEL 8800 HARFORD (4) 23a. Part1. Enter the distriction of commentation, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Heroin Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery. 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 200 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes has been signed to should to Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1, 24b. No 24a. Was an autopsy performed? page 1 Yes 2□No 25. Was case referred to medical examiner?
1 Xyes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene 2 this 28a. Date of Injury (Month, Day Year) 9-5-05 found 28c. Injury at Work? Certification; 27. Manner of Death 9-5-05 | Q:500 M | 1 C | 28c. Injume of Injumy - At home, farm, street, factory, office building, etc. (Specify) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2**X** No 2 Accident investigation Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Bural Royle Number City or Town, State) 5 N. Highland Avenue 4 Homicide found at home Baltimore, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

within 24 hours after or To the Funeral Direct completely filled in by

State Registrar 31. Date filed (Month, Day, Year) SEP 09 2005

29b. Signature and title of certifier

iasha

111 Penn Street, Baltimore, Maryland 21201 32. Re strar's Signature

ex aus

M.D.

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) Greenberg

ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 06, 2005

			1 - State Registrar	ate of Maryland		tment of H			giene 2 (005	29411
	Physici		1. Decedent's Name (First, Middle, Last)	ROWN				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic Examin Funeral	er	4a. Facility Name (If not institution, give street HOWARD COUNTY G 5. Social Security Number 6. Sex	and number) ENERAL HO 7. Age (In yrs. last	SP17	If Under 1 Year	Location of Death	1 A	4c. County	of Death	D
	Director		432-26-6928 1 ☐ M 2 Usual Residence of Decedent	2 X 1 81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day APRIL 22,	⁷ , 1924	ARKANSA	e (State or Foreign \ \S
	Marylan a-f show	ctor	MD 10b. County HOWARD		Town or Local JMB I A	tion					Inside City Limits 1X Yes 2 No
	h with the	al Director	10e. Street and Number 6417 ALLVIEW ROAD			10f. Zip Code 21046			10g. Citizen of W USA	hat Country	?
036	urs after deat al', or Items ?	by Funeral	1 Never Married 2 Married 1	las Decedent Ever in U.S. med Forces? ☐ Yes 2√3 No Yes, Give ear or Dates:	lf Y	s Decedent of Hi es, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - American k, White, etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental trygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other traumatic svent, "Ite Medical Exam as errital be notified at once.	Completed	15. Decedent's Education (Specify only highest grade cont Elementary/Secondary (0-12) C 12 2		(Give kin	NOT use retired,	furing most of wor	rking	16b. Kind of Bu		stry
land 2	ld be filed lental Hygi ked other itc svent,	To Be C	17. Father's Name (First, Middle, Last) JOHN W. DANIEL				18. Mother's Nar	me (First, Middle,			
	nd 2 shou alth and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type, P CHARLES M. BROWN / HUSBANI	·	_		and Number or Ru	ural Route Numbe			ode)
Baltimore,	Pages 1 a ment of Hea ant: If Itam ury or othe		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ral from State cem	e of Dispositi etery, cremat		9)	Date	20c. Location -	City or Town,	
Balt	permit. Departi Import any in		21. Signature of Funeral Service Licensee **Man & WM**	- *		lame and Addres	SPRING RO	LECK FUNER	RAL HOME, , MARYLAN	INC. 0 20707	
8760,	Physician and bhysician and the prival-transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequer	nce of):			resist		Int	oproximate terval Between Inset and Death days days
.O. Box 6	the death certiff by the attending ached for use as	Physician/Med	in the past 12 months?	yes, outcome of pregnanc □Live birth 2 □ Fetal de □Pregnant at time of deat □ Unknown	eath 3□Ed	ctopic pregnancy other (specify)			23d. Date Mor	e of delivery onth Da	ty Year
ords, P.	w requires that s been signed to should be deta	b	Part II. Other significant conditions contributions Chromic at all for	ting to death but not resulting to death but not resulting	ng in the unde	ertying cause give	on in Part I.	23e, Did to	obacco use contr es 2000		cause of death?
Vital Records,	sician: The law r s certificate has be lirector, page 2 sh	e Completed	anemia, pneun 25. Was case referred to medical	a with	hi	e exe gpona	tenja	24a. Was autop perfor	rmed? d 2 No 1	rior to compl leath?	r findings available letion of cause of
Division of Vi	Phy this ral d	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	1 Minpatient 2 LEH	Bb. Time of Injury		ar: 4 ☐ Nursing H	flome 5 ☐ Resident Particle 1		ed	Pouts Alumbar
<u>≥</u>	pital or A ours after eral Direc		4 Homicide	building, etc. (Specify)				City or Ton	n, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	n and/or inves	stigation, in my op	oinion, death occu	urred at the time,	cause(s) and mai date and place, a 29d. Date signed	and due to the	e cause(s)
	F 3 7 8		App, MO, FC			D					2005 CCP
	6		30. Name and address of person who comple	rive, Col	lums	int) MAI -	MDa	3644	N,VM	ν, ÷	ecp
Di	Sta Regist	rar	31. Date filed (Month, Play, Year)	32. Registrar's Signatur	A A	sel					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydieneo o or

		1	For State Registrar AMEND ITEM	State of Marylan	വ/⊔epa 7 വഴിൽ	artment of F Filificaterof	ieaith and iv Death		eg. No.	29417
			Decedent's Name (First, Middle, La	SI)	1_9/03	702 011		2. Date of Deat Month		3. Time of Death
	Physicia /Medic	al -	Harry	Bellos		41. O'h. T	of posts	Septemb	er 7, 2005	2:35 P M
	Examin	er	ta. Facility Name (If not institution, giver Greater Baltimor		or		r Location of Death		Baltimo	
	Funeral Director		5. Social Security Number 6. S 219-28-3597				If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, August		thelese /Ctate or Foreign
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		-		10d. Inside City Limits
	Maryl s-f sho	tor	MD Balti	Lmore C	Wings	Mills				1 ☐ Yes 2 🛣 No
	h with the 23s or 28s		10e. Street and Number 11 B Dld Coach l	ane		10f. Zip Code 2111	7	1	Og. Citizen of What C	•
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iteme 23a or 28a-f show any figury or other treumatic event, the Medical Exam for must be notified at anone.	by Fur	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No Korn If Yes, Give Year or Dates:	⊃ a ∣	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036	within 72 ho ene. then "natur ne wedeal	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup h kind of work done DO NOT use retire nanic	during most of work		16b. Kind of Business Cup Manufa	
מק	il Hygin other	Be Co	17. Father's Name (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ylar	ould by Menta arked	To E	Aristovoulis		zakis		Anastas		Capone	7'o Codel
Mar	d 2 should be and 27 is m	3.3	19a. Informant's Name/Relationship Billie Jo Bellos	• • • • • • • • • • • • • • • • • • • •			ch La., D		r. City or Town, State,	21117
more,	Pages 1 an ent of Hee nt: If Item 3 ry or other		20a. Method of Disposition 1X Burial 2 Cremation 3 (4 Donation 5 Other (Spec	Removal from State MD	Place of Dispo cemetery, cre Vet Ceme	osition (Name of matory or other placet, Garr. Fi	orest 9/16/	Date D5	20c. Location - City o Owings Mills	
Baltii	permit. I Departme importer any injur		21. Signature of Funeral Service Lice				ess of Facility Ruck U., Towson,		neral Home, ⊧	Inc.
V	filicate be executed // Medical and // Medical and as the bural-transit	Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	quence of):	TOSIS, FAV	os A Pance	EATIEC-BIL	u Ly PRIMARY	Approximate Interval Between Onset and Death ÜNKNOWN
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Вох	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death 3	□Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
ds, P.O.	uires that t signed by d be detad	ρ	Part II. Other significant conditions SEPTICE!		sulting in the	underlying cause gr	ven in Part I.			to the cause of death? Probably 4 Thinknown
of Vital Records,		Completed						24a. Was a autop perfor	sy prior to	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	7.60.0	Ot	hor	th (Check only or		anif.)
on of	ing Phys	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	4 🗆 Ruising n		ence 6 Other (Sp ow injury occurred	өспу)
Division	al or Attending after death. i Director: After d in by the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be age Blood of Injury At h	nome, farm, s ify)	treet, factory, office		28f. Location (S City or Tow	Street and Number or I m, State)	Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director. completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying I	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, dea ation and/or i	ath occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manner additional and place, and di	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	(0		29c. Licen	ise number		29d. Date signed (Mo	onth, Day, Year)
			Moward L	Kegelo	03a) (T	D o	X 8 8 8 7		Deptember	0, 2005
	8+1		30. Name and address of person whe	o completed cause of death (Ite	N. Cha	rles St.	, Rm. 400	14, Balt	6, MD. 0	21204
	St Regist	ate rar	31. Date filed (Month, Day, Year) SEP 0 9 200	B2. Registrar's Sign	nature	Ked)				

Belos, Harry

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 29418 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year September 5, 2005 Physician Clara I. Blamberg рм 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2307 Hammonds Ferry Road Baltimore Lansdowne Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 9, 1911 If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex **Funeral** Days 1□M 2X F Months 94 Yrs. Director 213-26-5579 Mary Tand Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a State 10b. County 28a-f ahow traumatic event, the Medical Examiner must be notified at MD Baltimore Lansdowne 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Itams 23a 2307 Hammonds Ferry Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0036 ö Specify: Specify: 3 →Widowed 4 Divorced Completed by "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sporting and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Store Owner Goods 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Beashears William Simon 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 is any injury or other tra Clyde Blamberg 2307 Hammonds Ferry Rd., Lansdowne, MD 21227 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Xemation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 9-6-2005 Baltimore, MD Signature of Funeral Person Liberts 22. Name and Address of Facility Ambrose Funeral Hone, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE HEART Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cokonary Ak

Due to (or as a consequence of): ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PULMONAKY HYPERTENSION Physician: The taw requires that the death certificate be executed Due to (or as a consequence of): nding physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 27 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown MULTIPLE HEPATIC MASSES Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 💢 No 24a. Was an autopsy performed 1 Yes 2√ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attanding I 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09/06/2005 D 22832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21075 5808 MAIN STREET ELKRIBGE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Joseph Registrar SEP 0 9 2005

Lake

LAMBERG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 1 per Dr. C84709/21/05dhb

Amend Items 4a, 10e, 26, 28e, f per ME/FH, G847, 09/09/05dhb

Certificate of Death

Reg. No. 200 For A Stata Registrar Reg. No. 201 Decedent's Name (First, Middle, Last) 2. Date of Death Brandon Pasque1 Braun Day Month Year **Physician** Poseue 1 Brandon Braun 2005 /Medical 4a. Facility yam (If not institution give street and number) 2623 Laurel Valley Court 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Abingdon Harford Court 7. Age (In yrs. last birthday) 31 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 214 86 0692 1 M 2 □ F Bartymore, MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 📉 No Maryland Harford Abingdon Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2623 Laurel Valley Court Garth 21009 USA death v Funerai 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status oe filed within 72 hours after dial Hygiene. Jother then "naturel", or Item Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: XX Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🙀 No Specify: Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Landscaper First Choices Lawnscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other treumatic event once. Be Pierre Vilnuere Barbara Jean Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mishelle L Musika (Sister) 240 Woodland Drive Southern Shores, NC 27949 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. September 6 2005 Baltimore, Maryland * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home PA 11750 Belair Road Kingsville, Md. 21087 23a. Part1. Enter the disease, or complications that caused he shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hanging **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai the use as I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 418 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has autopsy performed 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1. Yes 2 □ No funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 Cene 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Aftert Certification: 5 Pending 1 Natural Place of Injury - At home, farm, building, etc. (Specify) 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide on (Street and Nymber Lown, State) 226 28f. Locate City of street, factory, office 4 | Homicide Scene 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 32. Registrar's Signature ate filed (Month, Day, Year) State SEP 0 9 2005 COCCALL Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 1St 2005 SEPTEMBER 1:35 PM William (MMN) Boniface /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1**XX**M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Director 218-01-8084 July 19, 1916 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 1 No Director Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3219 Whitefield Road 21028 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes & No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Racing Editor Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fritz (nmn) Boniface (nmn) Judd Louisa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as Important: If item 27 Is any injury or other trau once. Mary L. Boniface / Wife 3219 Whitefield Road, Churchville, MD 21028 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ignatius Cath. Cem. 9-5-05 * 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature / Funer Pervice Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Enysician /Medical Due to (or as a consequence of): Examiner DISSEMINATED CANDIDIASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ENCEPHALOPATHY HEPATIC that initiated events resulting in death) Last burialphysician STAGE LIVER DISEASE Physiclan/Medical the as attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 212 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide ŏ 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) P19582 muchita andry 1st 2005 SEPTEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIVEDITA , BALTIMORE, MD -LOCH RAVEN BLVD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

o

of Vital Records,

Division

ORIGINAL

			State of Maryland / Department of Health and Certificate of Death	Mental Hyg	_	29421
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anne Greaves Blackmore	2. Date of Deat Month September	Day Year	Time of Death
*	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Holy Cross Hospital 5. Social Security Number 013-28-8241 6. Sex 1 \square M 2 \square F 70 Yrs. 4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		4c. County of Death Montgomery 9. Birthplace Country 1935 Massac	(State or Foreign
		ctor	Usual Residence of Decedent 10a. State	jilay 3,	10d.	Inside City Limits
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f ehow any injury or other treumatic event, its Medical Exam is frout to notified at ODCe.	by Funeral Director	106. Street and Number 627 Muriel Street 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 106. Zip Code 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Siew Year or Dates: 1 Yes 2 No Specify:		Og. Citizen of What Country? United Stat 14. Race - American I Black, White, etc. Specify: White	es ndian,
Baltimore, Maryland 21215-0036	iled within 72 hour Hygiene. ther then "neturel nt, I'm Wedicel E.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work done during most of working the properties of the	rking me (First, Middle, I	16b. Kind of Business/Indust Own Home Maiden Sumane)	ry
ryland	hould be f d Mental h marked of matic eve	To Be		Julia B	enson	7e)
e, Ma	1 and 2 s Health an em 27 le I ther treui		Thomas A. Blackmore / Husband 627 Muriel Street, Roc	kville,		2
Baltimor	permit. Pages Department of Importent: If it any injury or o		20a. Method of Disposition 1 Burial 2 The Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium Inc. 9, 2 21. Signature of Funeral Service Licensee M01433 Rockville, Inc. 300 Rockville, Maryland	ember 005	Bethesda, Mar	yland
760, 4	Autope of the process of the principle o	cal Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter undaritying Cause (Disease or injury that initiated events resulting in death) Last Cardio-Pulmonary Arrest Due to (or as a consequence of): b. Hyroglycemia Due to (or as a consequence of): C. Metabolic Acidosis Due to (or as a consequence of):		est, Ap	proximate erval Between set and Death
.O. Box 687	The law requires that the death cerificate are been signed by the attending physogge 2 should be detached for use as the	by Physician/Medic	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown 9		23d. Date of delivery Month Day	/ Year
Δ.	quires that t n signed by uld be detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		oacco use contribute to the ca	ause of death?
al Records,	10	e Completed	25. Was case referred to medical 26. Place of Dec		y prior to comple ned? death? No 1 Yes 2	tion of cause of
Division of Vital	To the Hospitel or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	examiner?	28d. Describe ho	once 6 Other (Specify) w injury occurred reet and Number or Rural Ro	ute Number,
Q	e Hospitel o 24 hours aft 8 Funerel Di etely filled in	edical Cer	29a. Certifier (Check only one) 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	a, and due to the ca	ause(s) and manner as stated	i. cause(s)
)		Me	29b. Signature and title of certifier D0038564		eptember 3, 20	
	20		30. Name and person who completed cause of death (Item 23a) (Type, Print) Dr. Maurice Cates M.D. 1500 Forest Glen Road, Silver S 31. Date filed (Month, Day, Year) 32. Registrar's Signature	pring, Ma	aryland 20910	
	Sta Regist		31. Date filed (Month Day, Year) 9 2005 32. Registrar's Signature			

				State of Maryland / Department of Health and N 1- For Registrar Certificate of Death		ne 2005 29422
		Physici /Medic		1. Decedent's Name (First, Middle, Last) Charles M. CONNELLY	2. Date of Death	Day Year 3. Time of Death 230 pm
		Examir		4a. Fecility Name (If not institution, give street and number) Oakcrest Village Parkville		4c. County of Death Baltimore
		Funeral Director		5. Social Security Number 6. Sex 7. Age In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min. Usual Residence of Decedent	8. Date of Birth Month, Day, Ye	9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country)
		Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location Baltimore Park Dille		10d. Inside City Limits 1 ☐ Yes 2 ☑No
30 mg	•	th with the Ma 23a or 28a-f ust be notifie	Funeral Director	8810 Walther Blud. #2019 21234	10g.	Citizen of What Country?
2	36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23s or 28s-1 show other traumatic event. If a Marical Exercitier must be notified at		11. Marital Status 1	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
05	215-0036	thin 72 hou e. an "nature Maulical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring	Dendix radio Corp.
18/2	and 21	be filed wintal Hygien ad other the event, Inc.	Be		e (First, Middle, Mai	
5 hr	Maryland	d 2 should be th and Mental t? Is marked c traumatic eve	To	Marth Frank CONNELLY Marc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Riv 180 Kiverwath	-/ 1	Dammer ity or Town, State, Zip Code) nopolis mD 2140
Hurson	Baltimore,	85=5		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from State		c. L. cation - City or Town, State
77	Baltir	permit. Pa Departmen Important: any injury once.		21. Signature of Fureral Service Licensee 22. Name and Address of Facility EVO	ns Funera	d chapel 2,00 21234
		Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		
		/Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
V	/	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
	68760,	ificate be e g physician as the buris		d		
	P.O. Box 68	The law requires that the death certificate be ate has been signed by the attending physicial page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
		w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
	Division of Vital Records,	sician: The law re s certificate has bee lirector, page 2 sho	Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
	Vita	Physician: r this certifica ral director, I	o Be (examiner?	h (Check only one)	
	ion of	Phy this	H-	1 Yes 2 No	ome 5 ☐ Residence 28d. Describe how i	e 6 Other (Specify) njury occurred
	Divis	al or Attar s after dea I Diractor d in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause red at the time, date	ə(s) and manner as stated. and place, and due to the cause(s)
		To t with To t	¥	29b. Signature and title of pertifier 29c. License number D T 3 11 7	29d.	Date signed (Month, Day, Year)
		10		30. Name and rod ess of person who completed cause of death (Item 23a) (Type, Print) To H (and many frod watth BI-J 31. Date filed (Month, Qay, Bea) Q 2005 32. Registrar's Signature	Patul	u mp 2/234
		Sta Registi		31. Date filed (Month, Sar, Pean 9 2005 32. Registrar's Signature)		

		-	For State Registrar		State of Mai	yland / De <i>C</i>	partment of F <i>ertificate of</i>	leaith <i>Death</i>	and Men n	ntal Hygie Reg.		05	294	23
ı	Physicia		1. Decedent's Name Shirley	(First, Middle, Las Ellswort						Date of Death Month	Pav 7	Year	3. Time of 0	Death OPM
	/Medic Examin		4a. Facility Name (If	not institution, give	street and number)	ita 1	4b. City, Town, o	or Location	of Death		4c. County	of Death		<u>~1</u>
	Funeral		5. Social Security No	umber 6. S	ex 7. Age	(In yrs. last birthdo	Months Days	If Unde Hours	or 24 Hrs. 8. I	Date of Birth (Month, Day Yo ULY	9. Birthplace (State or Foreign 1929 Michigan			Foreign
ı	Director		371-28-83 Usual Residence of	Decedent		76 Yrs			J	uly II,	1929			
	death with the Maryland ms 23a or 28a-f show	lor	10a. State W.VA.	Morgan		10c. City, Town or Paw Pav						10	0d. Inside City 1 ☐ Yes	
	r 28a-	Director	10e. Street and Nun				10f. Zip Code			10g	. Citizen of V	What Coun	try?	
	th with	aiD	301 Winch	nester St	reet, Apt.	"L"	25434				U.S.A	•		
	n 72 hours after death with the Marylan "naturel", or Itams 23a or 28a-f show Jolical Examities in the Institled at	by Funerai	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed	ed 2 <mark>K</mark> Married 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1947 1948	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2【X\00			Yes or No- an, etc.)		e - Americ ck, White, o		
215-003b	within 72 he lene. then "natu	Completed	(Speci	15. Decedent's Ed ify only highest gra ndary (0-12)		(G	cedent's Usual Occupive kind of work done a. DO NOT use retire	pation during mo ed)	ost of working		b. Kind of Bu		lustry	
7	filed within Hygiene. Ither then ant, Itte M	Con		9		Loc	omotive En			rst, Middle, Ma	ail Ro			
Maryland	ed ital	To Be	17. Father's Name (Martin Ed							te Elle				
Mar	s 1 and 2 should f Health and Men Item 27 is marka other treumatic		19a. Informant's Na Audrey Co				 Box 263, 							
Baltimore,			20a. Method of Disp	position	Removal from State	cemetery,	sposition (Name of crematory or other pla Of Faith	ice)	Date Sept10	, 2005Ba	c. Location -	-		ıd
Balti	permit. Page Department of Important: If any injury or once.		21 Signature of Fi	Lucil Confidence	1500		22. Name and Addr. E 1407 Old	ess of Fac Bruzda	zinski	Funeral	. Home	, P.A	and 21	221
					plications that caused tone cause on each line	he death. Do not	enter the mode of dy	ing, such a	as cardiac or re	spiratory arrest	,	SIGIL Y I	Approximate Interval Betw Onset and D	veen
г.	Physician /Medical		Immediate Cause (disease or condition resulting in death)	(Final in	a. Left II	consequence of):	ic Ischm	mic	STRO	KE			4 DAY	5
	Econiner	ē	Sequentially list con if any, leading to im	nditions, nmediate	b. — Due to (or as a	consequence of):								
V	ecuted and -transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	injury	C	consequence of):								
68760,	ficate be executed g physicien and ts the burial-transit	edicai E	,	l	_ d									
_	entifica ling ph	Med	IF FEMALE:		220 If yes outcome o	f programmy		-1-7-1			00.1.0	to at dath and		
O. Box	The law requires that the death certifi te has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Ves 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)									23d. Date of delivery Month Day Year		
<u> </u>	res that the de signed by the a l be detached f	by Pł			Contributing to death but		e underlying cause gr	ven in Par	tl.	23e. Did tobac		٠		
ord	w require been si should b	eted			ABETES M				- 4	1 Tes		(-	ably 4 □U	7
Division of Vital Records,		Completed	LYPE	d (3)	HUELEZ 100	eu rus) ~			24a. Was an autopsy performe	d?	prior to cor death? 1 \(\text{Yes}	psy findings a npletion of ca 2 No	use of
Vita	iclan: Th certificate rector, pag	Be	25. Was case refer examiner?	_	Hospital:	745-646-5-44	0	hon	ce of Death (C					
ot	Phys r this aral dir	. To	1 Yes 2 2	-	28a. Date of Injury	28b. Tim	e of 28c. Inju	ury at		5 Residence . Describe how			/)	
ion	Attending Physiclan: r death. ector: After this certifica	ation	1 Natural 2 Accident	5 Pending investigation		Year) Inju	,	ork? ∃Yes 2[□No					
Divis	al or Atte	Certification;	3 Suicide 4 Homicide	6 Could not be determined		ry - At home, farm (Specify)	, street, factory, office		28f.	Location (Stree City or Town,	et and Numb State)	oer or Ruma	I Route Numb	ber,
	To the Hospitel or Attending Physiclen: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)		hysician: To the best o miner: On the basis of and manner stat	examination and/o								
,	To th withir To th comp	Me	29b. Signature and	title of certifier) 11		29c. Licer	ise numbe	r /		. Date signe			
	net		30. Name and add	ress of person who	completed cause of de	ath (Item 23a) (Ty	pe, Print)	7 (05)			7,20	05
	1''		Dr. Gr	101	alden.	912 Se	Ion Drive	Cur	nberla	rd M	D 21	502	•	-
	Sta Regist	ate rar	31. Date filed (Mor	_		r's Signature	role i							

DHMH 17 Rev 1/2001

ORIGINAL

			_ For	State of Maryland	d / Depa	artment of H	ealth an	d Mental Hy		• • •	
			Stata Registrar		Cei	tificate of L	Death			005	29421
	Physicia	an	1. Decedent's Name (First, Middle, Las	11: 0	5 M	1		2. Date of De	Day	Year	3. Time of Death
	/Medic		Aa. Facility Name (If not institution, give		J. / /	4b. City, Town, or	Location of D	Death Depter	4c. County	of Death	// A
			The Villa				timo				
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	Hours N	Hrs. 8. Date of Bir Min. (Month, Da	th y Year)	9. Birthplac Country	ce (State or Foreign
			Usual Residence of Decedent	0.				tune -	1,1923		/ / _ /
death with the Maryland	show	_	10a. State 10b. County		, Town or Lo					100	d. Inside City Limits 1 中 Yes 2 □ No
the M	28a-f	ecto	10e. Street and Number		a17.	more 10f. Zip Code			10g. Citizen of	What Counts	
with	3a or	Ö		a Avenue		2/2	.12			LSA	y r
	ame 2 er mu	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin	? (Specify Yes or No uerto Rican, etc.)		ce - American	
	l, or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2ŪNo				y: Whi	- /
5-UU36 72 hours after	"natural", or Itame 23e or 28e-f show edical Examiner must be notified at	ted !	15. Decedent's Ed	ducation	16a. Deced	dent's Usual Occupa	tion		16b. Kind of B	usiness/Indu	stry
ith /	han "r a Med	Completed	(Specify only highest gra	College (1-4or 5+)	_	kind of work done d DO NOT use retired)			Ω	1:01	,
N pe	Hygie ther t	e Co	17. Father's Name (First, Middle, Last)	5+		ISTER O	18. Mother's	Name (First, Middle,	Maiden Suman	11910	<u> </u>
	rked o	To B	Steven J. C	obis			Ca	therin	2) W	FFU	
lary 2 sho	f Health and Mer tem 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) Relsions	19b. Mailir		nd Number o	r Rural Route Number	er, City or Town,	State, Zip C	
6, 6	Health em 27 ther tr		SISTERS OF ME 20a. Method of Disposition	RCJ ORGANIZATION	2000	E. No	Rthe.	RN Pak	20c. Location		
mor	0 = P		1 Description 3 □ 1 Description 1 Descripti	Removal from State	emetery, cren	natory or other place		/ /	20c. Location	City or Town	n, State
	pertmen cortant: / injury		21. Signature of Funeral Service Licer		00	N Cemeters	c of Engilibe	110/05	Dal	10 /1	70
n a	Depe Impo eny i		Hosten Cles	the	1	134 W	- HSh	TON FUL SAVING	Neral Ra.	21222	e, P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceused the death one cause on each line.	. Do not ent	er the mode of dying	, such as car	diac or respiratory a	rest,	l Ir	Approximate nterval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)			Cord	OVAS	men d.	esc		10705+
	xaminer			Due to (or as a consequ	ience or):						
P	#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
5U, /	sician and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):						
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≝ٍ هَ	ing phy e as th	a)	IF FEMALE:								
DOX	attend for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy				te of delivery onth D.	ay Year
. §	by the	hysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9 Unknown	aui s	Other (specify)					
S, T	igned by the attending p be detached for use as t	by P	Part II. Other significant conditions of	ontributing to death but not resu	liting in the u	nderlying cause give	n in Part I.				cause of death?
		eted						_ 10'	es 2 No	3 Probab	oly 4 □Unknown
I HECOFGS, The law requires t	2 5	ompieted				·		24a. Was autor perfo	sv	prior to comp death?	y findings available detion of cause of
	tificate tor, pa	e C	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only of	2 No	1 ☐ Yes 2	ØNo
<u> </u>	O	ToB	examiner? 1 ☐ Yes 2 ☐ No		ER/Outpatien	t 3 DOA Othe	r. 4 Nursir	ng Home 5 Resid		ier (Specify)	
O D Built	h. After th funeral	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	Work	at ? ′es 2 ∐ No	28d. Describe	now injury occur	red	
DIVISION For Attending	octor:	ificat	2 Accident investigation 3 Suicide 6 Could not b	e 28e. Place of Injury - At hor	me, farm, str		. 62 S 🗆 140		Street and Numb	per or Rural F	Route Number,
בַּ בַ	el Dire	Certification:	4 Homicide determined	building, etc. (Specify,)			City or Tou	vn, State)		
Ново	within 24 hours after death. To the Funerel Director; After the completely filled in by the funera	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my knowniner: On the basis of examinati	wledge, death ion and/or in	occurred at the tim vestigation, in my op	e, date and p inion, death o	lace, and due to the occurred at the time,	cause(s) and ma date and place,	anner as state and due to th	ed. ne cause(s)
o the	vithin To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signe		
_	> F U		mia.	- O Kronp 1	my	0	3186.	<i></i>	9/	8/05	-
	3		30. Name and address of person who	completed cause of Fath (Item	23a) (Type,				,	edi si	
	Sta	te.	31. Date filed (Month, Day, Year)	₹. Registrar's Signat	v ure	the The	1	13 act	md 2	-120/	
	Registr		SEP 0 9 200	S 2. Registrar's Signat	Riginal	de					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 29425 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 20/85 Physician 3:36 A LEO WILLIAM CERINO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore Center Towson 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1X M 2□ F 218-26-2455 MARYLAND Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County rithen "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at 1 ☐ Yes 2 X No BALTIMORE PARKVILLE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1805 BRIARCLIFF ROAD 21234 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 X)Yes 2 □ No If Yes, Give Year or Dates: KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status e filed within 72 hours after di Il Hygiene. other then "natural", or item Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☐XIo Specify: Specify: δ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BON SECOURS HOSPITAL MAINTENANCE SUPERVISOR permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if item 27 is marked other th any injury or other traumatic event, the 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE VIRGINIA THOMPSON ALBERT J. CERINO 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1805 BRIARCLIFF ROAD PARKVILLE, MD MARGARET CERINO/WIFE 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MOST HOLY REDEEMER 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/12/2005 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) CEMETERY 21. Signatur of Funeral Service Ligensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Proysician Metastatic Carcinoma of unknown Unknown /Medical Due to (or as a consequence of): Examiner primary site Sequentially list conditions, aua to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ad by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð

signed b been sig Completed has t certificate Be 2 this After the Certification: Director:

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

death.

within 24 hours after To the Funeral Dire

in by

Medical

Baltimore, Maryland 21215-0036

4 Unknown

1 Yes 2 No 3 Probably

autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one)

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D 51852

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day Year)

M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204 DAVID A. BRINKER. 31. Date filed (Month, Day, Year)

State Registrar

SEP 0 9 2005

5 Pending

investigation

6 Could not be determined

25. Was case referred to medical

1 ☐ Yes 2 No

Magner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier mid

examiner?



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2 X ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

-05787		Please			delible ink. Ensure a artment of Health and		_				
	-	For State Registrar	State of M		rtificate of Death	Re	g. No. 2005 29	9426			
Physicia /Medic	n	Decedent's Name (First, Middle, Last	•	A L. CHANI		2. Date of Death Month August	Day Year 2005 4:47	of Death			
Examin		4a. Facility Name (If not institution, give	_)	4b. City, Town, or Location of Dea	th	4c. County of Death				
		Johns Hopkins Ho 5. Social Security Number 6. S		ge (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs		N/A 9. Birthplace (Star Country)	te or Foreign			
Funeral Director			□ X 4 2□ F	29 Yrs.	Months Days Hours Min	Sep 23					
D .		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation		10d. Inside	City Limits			
e Marylan ta-f show	ctor	MD Tool County			BALTIMORE		1 (X Y	es 2□No			
ire, Maryland 21215-0036 s. 1 end 2 should be filed within 72 hours after death with the Maryland it health and Mental Hygiene. It health and Mental Hygiene. It marked other then "naturel", or Itema 23s or 28s-f show other traumatic event, the Medical Examinat must be recitified at	Funeral Director	10e. Street and Number 204 N. CURLEY			10f. Zip Code 21224	10	g. Citizen of What Country? U.S.A.				
ema 2	iner	11. Marital Status	12. Was Deceden Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)	14. Race - American Indian Black, White, etc.	,			
036 urs after el', or lte	٥	1 X lever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ MNo Specify:		Specify: Black				
5-00	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Usual Occupation a kind of work done during most of w DO NOT use retired)	orking	6b. Kind of Business/Industry				
21215-0036 Id within 72 hours all giene. or then "naturel", or the Medical Exam.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) life.	FIRST MATE		CRUISE SHIPS	3			
laryland 2121 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Market	Be	12TH 17. Father's Name (First, Middle, Last,	L CHANDLER		18. Mother's Na	ame (First, Middle, A	faiden Sumame) ERA JUNIOR				
Maryland to 2 should be file lith and Mental Hy 27 is merked oth traumatic event	ပ	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street and Number or F	Rural Route Number,					
end 2 ealth a m 27 is		SONDERA JUNIOR M	other		204 N. CURLEY BALTIM	VALUE OF THE PARTY	24 20c. Location - City or Town, State				
TOPE		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Dother (Specif		9	S MEMORIAL PARK	09/06/05	MD	1			
Baltimore, Mapernit. Pages 1 end 2 Deperment of Health a Important: if Item 27 in eny Injury or other training.		21. Signature Vuneral Service Licer		00cm 2	2. Name and Address of Facility Miller's Metropolita	an Chapel P.C					
m 40304	-,	23a. Part1. Enter the disease, or com shock, or head failure. List only	plications that cause	ed the death. Do not en	1639 North Broads	vay Baltimore ac or respiratory arre	Maryland 21213 est, Approxi	mate			
Physician /Medical Examiner		shock, or head failure. List only, Immediate Cause (Final disease or condition resulting in death)	a//	s a consequence of):	Gurshotl	Vounds	Onset a	Between nd Death			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. Due to (or a	s a consequence of):							
60, be executed sician and buriat-transit	ai Examiner	ш									
687(tificate to ng physical as the b		•	d								
BOX death cer	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year			
Records, P.O. The law requires that the date has been signed by the lage 2 should be detached	d by Ph	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause	of death?			
Division of Vital Records, I or Attending Physician: The law requires tafter death. Director: After this certificate hes been signed in by the funeral director, page 2 should be	Completed					24a. Was a autops	y prior to completion ned?	ngs available of cause of			
Vital Re iclan: The iccertificate herector, page 2	ပို	25. Was case referred to medical			26 Blace of D	eath C eck onl on	No 1XYes 2 No				
Vision of Vita Attending Physician: r death. •ctor: After this certification by the funeral director.	To Be	examiner?	Hospital: 1 Xinpa	tient 2 ER/Outpatie	Other	= 10/02-2:02	ence 6 Other (Specify)				
on of	T :uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of In		of 28c. Injury at Work?	28d. Describe ho	ow injury occurred				
iSior Mtendin death. ctor: Afr	atic	2 Accident investigation	n 8/28/	02 022	M 1 ☐ Yes 2 No	Sub	eutstal				
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Medical Certification;	3 Suicide 6 Could not to determined	286. Place of I	njury - At home, farm, s etc. (Specify)	treet, factory, office	28f. Location (St City or Town	reet and Number or Rural Route I n, State) 	to MO			
Hospital 24 hours a Funeral I	licai (29a. Certifier 1 Certifying P	hysician: To the be- miner. On the casis and manner	of examination and/or i	ith occurred at the time, date and pla	ce, and due to the co	ause(s) and manner as stated. all and place, and due to the eac	55(8)			
To the vithin 2 To the comple	Mec	29b. Signabuse and title of certifier	and (100110)		29c. License number	2	9d. Date signed (Month, Day, Yea	ir)			
FSFO		> Clarko	ND		O.C.M.E.		August 29, 2005				
7		30. Name and address of person who	completed cause o	f death (Item 23a) (Type		1+imoro	Maryland 21201				
· ·		31. Date filed (Month, Day, Year)	JUKE N	tunda Cimatura	l Penn Street, Ba	шиноге,	ratytanu 21201				
Sta Regist	ate rar	SEP 0 9 20	Ub Marin	au Di Andre	ale						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death sept. 3, **Physician** ^{Day}005 Jessie Hayes Clifton 11:50PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4501 Wilkens Ave. Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 12-115-115 | 315 5. Social Security Number 216–24–2938 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F 89 Virginia Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 is markad othar than "natural", or Itams 23a or 28a-f shov traumatic avant, it a Madical Examinar must be motified at Maryland N/A Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 Wilkens Ave. 21229 U. S. A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mantal Hygiene. Important: If item 27 is marked othar than "natural", or Itan any injury or othar traumatic avent, the Medical Examination. Once. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Sales Woman Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur A. Blackwell Lima Miles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Scott, daughter 5456 Thunder Hill Rd. Columbia, MD. 20b. Place of Disposition (Name of cometery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 09-07-05 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licensee Takens 1328 Sulphur Spring Rd. 21227 Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardine Physician Horrs /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-transit law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) signed by to Id be detach Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 Tyes 2 No 1☐ Yes director 25. Was case referred to medical 26. Place of Death Check onl one examiner' Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Attanding P er death. After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or At 24 hours after of 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha Z 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ()367+6 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burnie Maryland 21060 Roesler Rd, Glen 115 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artme <i>rtifica</i>	nt of He te of D	ealth and r Death		gien ę Reg. No.	.005	29428
	Physicia		1. Decedent's Name (First, Middle, Last,		\ - 1.1	-			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	Ida C. E	Dodd	4b. Cit	v. Town. or 1	ocation of Death	9	1 4c.	2005 County of Deatl	11:30 a ^M
	Examin	er	Future Care 01			alto						
	Funeral Director		5. Social Security Number 6. Security Number 1 6. S	7. Age	(In yrs. last birthday, 90 Yrs.	Month:		Hours Min.	8. Date of Bir (Month Da 2-9-	th Y915	9. Birti Co.	nplace (State or Foreign untry) Md
	and and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation						10d. Inside City Limits
	Maryl a-f eho	tor	Md	Balto	Pikesvi1	1e						1 □ Yes 2 No
	h with the 13a or 28a st be not	al Director	10e. Street and Number 31 Rosland Court			10f. Z	ip Code 2]	1208		10g. Citi	zen of What Co USA	untry?
036	within 72 hours after death with the Maryland ene. Than "natural", or itema 23e or 28e-f ehow Ite Mudical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13.		edent of His ecify Cuban 2 No	panic Origin? (S , Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White Specify:	
Maryland 21215-0036	d within 72 ho piene. r than "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(Give	DO NOT		tion uring most of wor Worker			nd of Business/ Private	
nd 2	filed Hygi ther	Be Co	8th grade 17. Father's Name (First, Middle, Last)		1			18. Mother's Nan	ne (First, Middle	, Maiden	Sumame)	
ylai		To	George Tates 19a. Informant's Name/Relationship (T)	una Reint)	10b Mail	ina Addro	ss /Street a	Isabe		oates		Tip Code3
	tra tra		William Gilmore			Ros1	-		sville,			up coda)
Baltimore,	Pages 1 and 2 nent of Health int: If Item 27 iny or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disp cometery, cre Garrison			1	Date 2-2005		cation - City or	
Baltii	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licens				and Address		arch F/	H We	est	
Ψ,	9		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused ne cause on each line	the death. Do not en	iter the m						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	De	men	to	4					Onset and Death
14	Examiner			Due to (or as a	consequence of):	0	I'B	reas	t oc	2 1/2	005	
\ /	sit	lner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):		1	0-01				
FX.	ficate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):							
68760,	ate be hysicia the bur	edical		d								
Box	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death 3	□Ectopic □ Other (pregnancy (specify)			:	23d. Date of deli Month	ivery Day Year
P.0	es that the digned by the be detached		Part II. Other significant conditions co		t not resulting in the	underlying	g cause give	n in Part I.	23e. Did	obacco u	ise contribute to	the cause of death?
rds,	equires an sign	ed by							10	Yes 2[□No 3□Pr	obably 4 Dinknown
Record	The law requisate has been page 2 should	Completed							24a. Was auto perf 1 Yes	psy ormed?	death?	topsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	In a shall			04.	26. Place of Dea	ath (Check only			
of \	× 5 ₽	.: To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injur	y 28b. Time		DOA Othe	4 Nursing F	lome 5 Res			Dify)
ion	ath. r: After se funer	atlor	1.☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	М	Work	? ′es 2 □ No				
Division	To the Hospital or Attending Phwithin 24 hours after daath. To the Funaral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, s . (Specify)	treet, fact	ory, office		28f. Location City or To	Street an wn, State	d Number or Ru)	ural Route Number,
	Hospli 24 hour Funar etely fill	Medical	29a. Certifier 1 Certifying Phy (Check only one)	iner: On the best of and manner sta	examination and/or i	th occurrence	ed at the time on, in my op	e, date and place inion, death occu	, and due to the irred at the time.	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certific			2	29c. License	number		29d. Dat	e signed (Monta	h, Day, Year)
	^		Wines	2	5, en	7	ille	42	1_	9	16/0	1
	19		30. Name and address of person who of Willie B. M.	ompleted cause of de	4 413 C	Print)	vo~	weal	fe A	Va	expres	Ville un
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	S	.0	S _ 3				1 3

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** VanKiRK DaveNDORT 215A 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Village If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 58X 1127M 2□F Months Yarch 24,1949 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Middle more 10e. Street and Number 10g. Citizen of What Country? USA or Items 23a ZUN by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Item any injury or other traumatic event. The Medical Exament 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify(Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) O WORKE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be VanKiRK Daven DORT 2 Leacoc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9812 Ma Middle mo 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1 □ Burial 2 W Cremation 3 □ Removal from State 8 05 4 □ Donation 5 □ Other (Specify) Hount CEMERRY 22 Name and Address of Ficility
Bradley - A.Sh. Fox 21. Sinna ve of Funeral Service Lig FUNERA! 134 SPRING W, 110 W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACRUIRED IMMUNE Physician DEFICIENCY SYNUROME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatb2 TENSION 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No certificate has 1 Yes 2 1 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other Al Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director; A 2 🗀 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEASAN 821 BATTIMORE NORTH EUTAW STREE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 0 9 2005 Registrar GOBALL

		For State Registrar			partment of ertificate of		Re	g. No.200	15 2943	
Physicia		Decedent's Name (First, Middle, Last)	Arno D	illensege	r		2. Date of Death Month September	Day Y	3. Time of Death 05 1:23 A	
/Medic Examin		4a. Facility Name (If not institution, give s Laurel Regional Ho	treet and number)		-	or Location of Death	1	4c. County of Prince		
Funeral Director		212-31-4862	7. Ag	e (In yrs. last birthda 45 Yrs.	y) If Under 1 Yea Months Day:		8. Date of Birth (Month, Day, Jan 26,	Year) 9	Birthplace (State or Fore Country) Germany	
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard		10c. City, Town or		10d. Inside City Lim 1 ☐ Yes 2 🔯				
or 28a	Direc	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-1 show other treumatic event, the Medical Examinat must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 🔀 Married	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give	Ever in U.S. 13	20723 3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🔊 No	Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Black,	American Indian, White, etc.	
within 72 hours ene. then "neturel" he Medical Ex	npleted b	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	(Gi life	. DO NOT use retir	e during most of wor red)	king	White 16b. Kind of Business/Industry		
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ould be f Mental F warked of	To Be	Karl-Heinz Dillens	seger				Hakewesse			
2 should be and Mental Is marked (-	19a. Informant's Name/Relationship (Type	pe, Print)	19b. Ma	iling Address (Stree	et and Number or Ru	ral Route Number,	City or Town, St	ate, Zip Code)	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tre-		Dominique Dillense 20a. Method of Disposition 1 Burial 2 Cremation 3 R		the latest to	l Mayflow position (Name of rematory or other pi	er Court,			d 20723 ty or Town, State	
Page tment tant: It		`4 □Donation 5 □ Other (Specify)			y's Cemet	4	9, 05 I	aurel,	Maryland	
permit Depar Impor any in		21. Signal re if Fyneral Service licens 23a. Part1. Enter the disease, or compli	1/m	M00773	313 Talb	n Funeral ott Ave.	Laurel, M	Maryland	20707-4389	
Iticate be executed Medical Examiner Substitution of the printer	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as	lic Liver a consequence of): a consequence of): a consequence of):	Disease				Interval Between Onset and Death months	
the death cert by the attending ached for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	B⊟Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of Month	•	
w requires that been signed b should be det	þ	Part II. Other significant conditions cor Epistaxis, Coagul		_	underlying cause g	oven in Part I.			ute to the cause of death?	
The la ate has page 2	Completed	Alcoholism, Edema	a, Anemia	, Hypokale	emia		24a. Was ar autopsy perform 1 Yes 2	pric	re autopsy findings availal or to completion of cause of ath? I Yes 2 \textsty\No	
Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	tlon; To Be	25. Was case referred to medical examiner? 1	ospital: 1 K) Inpatie 28a. Date of Inju (Month, Day	int 2 ER/Outpat ry 28b. Time (Year)	of 28c. Inj	ther: 4 🗆 Nursing H	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
i tte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, c. (Specify)			28f. Location (Str. City or Town,	eet and Number , State)	or Rural Route Number,	
ne Hospitel n 24 hours a ne Funerel C	edical (29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	ner: On the best of and manner sta	examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and mann te and place, and	er as stated. d due to the cause(s)	
To the within 2 To the complet	M	29b. Signature and title of certifier	m			nse number			Month, Day, Year)	
10		30. Name and address of person who co						Sept. 6,		
1		Pritam S. Saini,	M.D. 910	Ol Cherry	Tano Su	i+0 211 1	aurol M	Lace Liver	20700	

		•	For State Registrar	State of Mary	land / De	epai C <i>ert</i>	tment of He <i>ificate of D</i>	ealth a <i>Death</i>	nd Me	ental Hy	giene Reg. No.	2005	29431		
-			1. Decedent's Name (First, Middle, Las					•		2. Date of De Month	ath Day	Year	3. Time of Death		
	Physicia /Medic		REXFORD	DAN	50					AUG	30.	2002	2220 M		
	Examin		4a. Facility Name (If not institution, give	e street and number)	and number) 4b. City, Town, or Location of Dea							4c. County of Death			
			HOWARD COUNTY GENERA 5. Social Security Number 6. S		yrs. last birtho	dayl	COLUMBIA	If Under 2	4 Hrs.	9 Date of Bird		HOWARD	anlano (State or Foreign		
I.	Funeral Director		128-64-2106	X M 2 □ F 59	Yrs. last billing		Months Days	Hours	Min.	B. Date of Bin (Month, Da EPT. 27,	1945	GHA	nplace (State or Foreign untry) NA		
	land		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	or Loca	ation						10d. Inside City Limits		
	Mary First	to	MD HOWARD		COLUMBI	I A							1 X Yes 2 □ No		
	th the	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Co	untry?		
	ath wi	ral	6331 LORING DRIVE				21045				US				
5-0036	within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28a-f show the Medical Examinet must be medified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S.		as Decedent of His Yes, specify Cuban ☐ Yes 2☐ No	spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)		14. Race - Ame Black, White Specify: BL			
S C	72 ho	Completed	15. Decedent's Ec (Specify only highest gra	ducation	16a. D	ecede	nt's Usual Occupat ind of work done du	tion	of working		16b. Ki	nd of Business/I	ndustry		
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anc	be de la la la la la la la la la la la la la	Be c	JOSEPH DANSO							A. AKWE		Juliane)			
Maryland	ë p E E	은	19a. Informant's Name/Relationship (Type, Print)	19b. M	Mailing	Address (Street ar					r Town, State, Z	lip Code)		
	nd 2 ulth a 27 ie r tre		AUDREY D. PREMPEH /	DAUGHTER	63	331	LORING DRIV	VE, CO	LUMBIA	A, MARYL	AND 2	1045			
e,			20a. Method of Disposition 1 💆 Burial 2 □ Cremation 3 □		Ob. Place of D)isposi crema	tion (Name of atory or other place,)	Da	ite	20c. Lo	cation - City or	Town, State		
Ĕ	Pages ment of ent; ff it ury or o		`4 □Donation 5 □ Other (Specif	(1)	ID NATIO	NAL	CEMETERY	Se	ept. 1	7, 2005	L	AUREL, MA	RYLAND		
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature Financial Service Licer	Will -			Name and Address 601 SANDY			ECK FUNE LAUREL	RAL H , MAR	OME, INC. YLAND 207	07		
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.			the mode of dying,					5	Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of)):			0						
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_	entific ding p		IF FEMALE:	22c. If was outcome of n	roan anov										
P.O. Box	The law requires that the death certificate has been signed by the attending to 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Year			
	s that med b e deta	by Pi	Part II. Other significant conditions of	ontributing to death but no	ot resulting in th	he und	derlying cause giver	n in Part I.		23e. Did to	obacco u	se contribute to	the cause of death?		
ğ	w require baan sig should b		Avenia Co	nku penid						1/2	(es 2[□No 3□Pro	obably 4 Unknown		
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Ita	Physicien: The r this certificate I aral director, page	Be (25. Was case referred to medical examiner?						of Death	(Check only c	ne)				
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2	alor A after I Dira d in b	Certification;	4 Homicide	building, etc. (S			,,		ļ	City or Tov	vn, State,)			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Diractor: After this certifica completely filled in by the funeral director, g	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the best of my niner: On the basis of exa and manner stated.	y knowledge, o mination and/o	death of	occurred at the time estigation, in my opi	e, date and inion, deat	place, ar h occurred	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)		
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	Ω		> Pritem			>		899			-	7 3/0	(00)		
	. 1		30. Name and address of person who	completed cause of death	(Item 23a) (Ty	ype, P	rint) PRIT,	AMA	NDS	207	80				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature										
	Regist	ar	SEP 0 9 200	Marie 1	IN AS	SAG	to the same of the								

			For State Registrar	State of Ma	ıryland	d / Depa <i>Cei</i>	artment of Hertificate of L	ealth and Death	d Mental Hy	/giene Reg. No	200	5 2	9432
	Dhysieir		1. Decedent's Name (First, Middle, La.		5				2. Date of D	eath Da	y Yea	r	Time of Death
	Physicia /Medic	al	Joseph Alb		Rez	son		1	Septem		County of De		: 55 AM
	Examin	er	4a. Facility Name (If not institution, giv Veteran's Affai				Balti	eatn		N/A	atn		
	Funeral		Social Security Number 6. S	Sex 7. Age	(In yrs. la	ast birthday)				irth ay, Year)		Birthplace ((State or Foreign
	Director		213-30-7150 Usual Residence of Decedent	1X M 2□F 7	2	Yrs.			October	12,	1932 N	lew Yor	
	yland now		10a. State 10b. County		10c. City	, Town or Lo	ocation				-		nside City Limits
	e Mar Be-f st	ctor	Maryland N/A		Balti	imore							Yes 2 □ No
	with th	Dire	3417 Roselawn Avenue				10f. Zip Code 21214			10g. Ci	tizen of What USA	Country?	
	death ms 23	eral	11. Marital Status	12. Was Decedent E	Ever in U.S	S. 13.	Was Decedent of Hi	spanic Origin?	(Specify Yes or N	0-	14. Race - Ar		dian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show entry injury or other treumatic event, the Medical Examinational to institled at once.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☑ N If Yes, Give Year or Dates:	^{lo} Korea		If Yes, specify Cubar 1 ☐ Yes 2 1 No	Specify:	deno rican, etc.)		Black, W		
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ylaı	ould b Menta sarked	To	Hubert Dickerson Sr.						B. Dzierzy				
Maryland	d 2 sh th and th and ?7 is m treum		19a. Informant's Name/Relationship (Frank Lidinsky/Attorr	**		1	ng Address <i>(Street a</i> LaSalle Road			-			
	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. PI	lace of Dispo	osition (Name of		Date		ocation - City		
Baltimore,	Page ment o ent: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special Control of Co	fy)			matory or other place em. Garrison		9/14/05	Owing	gs Mills	Mary1	and
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Lice	nsee Christina Autox	L. Hi	1ton 2	2. Name and Addres eonard J. R 5305 Harford	s of Facility Ruck Inc I Road E	Båltimore, 1	Maryla	and 212	14	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that caused one cause on each lin	the death	. Do not en	ter the mode of dying	g, such as care	diac or respiratory	arrest,		Inte	roximate rval Between set and Death
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Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 4 ☐ Pregnant at	ic. If yes, outcome of pregnancy 1 Clive birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of o Month	delivery Day	Year
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Ś	sign sign d be	þ	Part II. Other significant conditions Psoriatic a	-	ut not resu	ulting in the u	inderlying cause give	en in Part I.		Tobacco Yes 2	use contribute		use of death? 4 □Unknown
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Vit	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 DOA Othe	D.F.	Death (Check only		6 ∏Other (S	pecify)	
		T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju. (Month, Da)		28b. Time o			28d. Describe			,,,,	
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DIX	tel or Attendii s after death. el Director: A ed in by the fu	Certification:	4 Homicide determined	28e. Place of Inji building, et	c. (Specify	/)	reet, factory, office			own, Stat		710707	310 144111201,
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	6+1		30. Name and address of person who	completed cause of d	_	23a) (Type.	Print) Green	St.	Baltino	re	MD 2	1201	/
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			State of Maryland / D	epartment of Health and Mental Hy Dertificate of Death	
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Elmer Elsworth Dunn Sr.	2. Date of Do Sep Teml	eath 3. Time of Death
	Examir	er	4a. Fecility Name (If not institution, give street and number) Chesapeake Hospice House	4b. City, Town, or Location of Death Linthicum	4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 215-24-0053 1 M 2 F 76 Yr 76 Yr 76	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. AUG •	9. Birthplace (State or Foreign Country) MD
	Maryland	tor	10a. State 10b. County 10c. City, Town Maryland Anne Arundel	or Location Pasadena	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the a or 284 be not	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	death ms 23	neral	765 Powhatan Beach Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA p- 14. Race - American Indian,
9036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examination and injury or 250.	d by Fur	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	Black, White, etc. Specify: White
21215-0036	thin 72 h e. en "natu Medical	Completed by	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired)	16b. Kind of Business/Industry
21	filed wit Hygiene other tha	Con	12 4 (CPA	acconting
and	d be fi	o Be	17. Father's Name (First, Middle, Last) Edward M Dunn Sr	18. Mother's Name (First, Middle Virginia	
Maryland	should and Men s marke umatic	To.		VII GIIII Q Mailing Address (Street and Number or Rural Route Numb	Clark er, City or Town, State, Zip Code)
	end 2 ealth a m 27 is		Margaret Dunn spouse	765 Powhatan Beach Road	
nore	ages 1 nt of H t: If ite / or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	isposition (Name of Date crematory or other place)	20c. Location - City or Town, State
Baltimore,	permit. P. Departme Importent any injury		'4 □Donation 5 □Other (Specify) □ Glen H 21. Signature of Funeral Service Dicenses	aven Cemetery 9/10/2005	Glen Burnie MD JS Funeral Home P.A.
8	9 9 E 2 9		Max Shil	3111 Mountain Road Pas	adena MD 21122
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of	Sul He most hope	rrest, Approximate Interval Between Onset and Death
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	0	•
,092	te be executed ysician and he burial-transit	cal Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of d	:	
P.O. Box 68	Physicien: The law requires that the death certificate be executed tribs certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
	w requires that been signed to should be det	ed by P	Part II. Dther significant conditions contributing to death but not resulting in t	coron Order Diser 10	obacco use contribute to the cause of death? Yes 225No 3 Probably 4 Unknown
Il Records,	The law re cate has be page 2 sho	Completed by		24a. Was autor perfo 1	
of Vital	sicien: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Innation 2 SP/Outs	26. Place of Death (Check only	11110
on of	ding Physin. Ih. After this funeral di	tlon: To	1	te of 28c. Injury at 28d. Describe	dence 6 (QOther (Specify) 1 Vistorial how injury occurred
Division	el or Atten s after deal I Director id in by the	ertifica	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		Street and Number or Rural Route Number, wn. State)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, (2 Madical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, and due to the or investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the to the comp	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	VI		30. Name and address of person who completed cause of death (Item 23a) (Ty	(na Print)	39pter, 8, 6005
_	107		See Name and address or person with outpleted cause of death (frem 23a) (1)	Hospided Drive, Ele	2061
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9 2005	the South &	1

		For State Registrar	State of Maryland		ment of He ficate of D			en 2005	29431
Physic /Medi		1. Decedent's Name (First, Middle, La	NATHANIEL	_ DAVI	S		2. Date of Death Month	Day Year P 1, 2005	3. Time of Death 6:30
Exami			ARTLAND HOSPICE		o. City, Town, or L	ARBU		4c. County of Dea	
Funeral Director			Sex 7. Age (<i>In yrs. la</i> 1		onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 14,	Year) C	thplace (State or Foreigountry) CAROLINA
fiedat	tor	10a. State 10b. County MD	10c. City,	Town or Locat		IMORE			10d. Inside City Limi 1 X Yes 2 ☐ N
3a or 28a st be nati	al Director	10e. Street and Number 1617 N. CALVERT ST			10f. Zip Code	02	10	g. Citizen of What C	*
incides area deall min are may have fure!; or items 23a or 28a-1 show all Evaluties I be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If Y	s Decedent of Hispes, specify Cuban, Yes 2 X No	panic Origin? (Sp. Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
than "nai	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give kin life. DO	t's Usual Occupati d of work done du NOT use retired) ONSTRUCT	ring most of work	ing	6b. Kind of Business	Vindustry RUCTION
ntal Hyg nd otha evant,	To Be C	17. Father's Name (First, Middle, Las JOHN	DAVIS		1	8. Mother's Name	e (First, Middle, M M	aiden Sumame) INNIE	
	-	19a. Informant's Name/Relationship LOUISE DAVIS Wife	(Type, Print)	_				City or Town, State, E, MARYLANI	
nent of Health and the strain of Health and the strain of Health and the strain of the		20a. Method of Disposition 1 Burial 2 Cremation 3 4 4 Doration 5 Other (Special	Pemoval from State	-	on (Name of ory or other place) ENS OF FAIT	0/-	7 / 05 2	0c. Location - City o	Town, State
Department of Pimportant: If its any injury or of once.		21. Signature of Embed Service Lio	hiller	22. N	ame and Address MILLER'S 1639 NO	METROPO	OLITAN CHA OWAY BALT	PEL, P.C. IMORE, MAR	YLAND 21213
A second of the standard of th		disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) d.	ence of):	ic pr		78 CA	UCOR	
by the attending photoched for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 □E	etopic pregnancy ther (specify)			23d. Date of de Month	elivery Day Year
is been signed by	Completed by Ph	Part II. Other significant conditions DLAS TS CRUE GWA	contributing to death but not resur	ting in the und	orlying cause given	n in Part I.		2 No 3 F	o the cause of death? robably 4 Onkno
	Be Com	25. Was case referred to medical examiner?	Ry ARAFIN	4 0		177	perform	Mo 1 □ Ye	
After this funeral di	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA Other 28c. Injury a Work? M 1 Ye	4 Nuising no	ome 5 Resider 28d. Describe how	nce 6 Other (Sp w injury occurred	ecify)
rs after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not determine	building, etc. (Specify,	·)			City or Town,		
	edical	one)	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	vledge, death o ion and/or inves		·			
tha Funa	0				29c. License	number	29	d. Date signed (Mor	un, Day, Year)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	Aturn	·	04	7934	A	EPTAMBI	5/2, 2vi

			For State Registrar	tate of Marylan	d / Depa <i>Cei</i>	artment of H <i>rtificate of L</i>	lealth and N Death	lental Hy	gien e Reg. No.	005	29435
	Physicia	ın	Decedent's Name (First, Middle, Last)					2. Date of De	eath Day		3. Time of Death
	/Medic	al .	Anna Marie Ea la. Facility Name (If not institution, give stree	ster et and number)		4b. City, Town, or	r Location of Death	Dest.	4c. (2005 County of Death	104
			Naviner Healt	9 of Bel A	-,-	Bel- If Under 1 Year	A F V If Under 24 Hrs.	0 D-11 B:	1	targor	-d
	uneral irector		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. 97)		Months Days	Hours Min.	8. Date of Bin (Month, Da July 6	, 190)8 Mar	place (State or Foreign ntry) Yland
and	A C		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
death with the Maryland	a-f sho	tor	Maryland Harford	Be	el Air						1 ☐ Yes 2 ☐ No
vith the	or 28 be not	Director	10e. Street and Number			10f. Zip Code	.1.4		10g. Citiz	zen of What Cou	ntry?
death v	rns 23s	eral		Was Decedent Ever in U.	S. 13.	210 Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No	p- 1	USA 14. Race - Ameri	
-0	el', or items 23a or 28a-f show Examinar nast be natified at	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give		f Yes, specify Cuba 1 □ Yes 2 🛣 No	Specify:	Hican, etc.)	1	Black, White, Specify:	white
-000 Z hours	"naturel", edical Exa		3 Widowed 4 □ Divorced 15. Decedent's Educati	Year or Dates:	16a. Dece	dent's Usual Occupa	ation		16b. Kir	nd of Business/Ir	ndustry
Maryland 21215-0036 to a should be filed within 72 hours after the and Mental Housine.	Department of Instant and recent in 1990 or natur important: if lean 27 is marked other than "natur any injury or other treumetic event, the Medical once.	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	during most or work	ang		ate High ninistra	
d 27	ent. In	Be Co	10 17. Father's Name (First, Middle, Last)	-	Secr	etary	18. Mother's Nam		, Maiden .	Sumame)	
ylan Vlabe	arked etic ev	To B	Max (nmn) Schrat	ke			Maude	(nmn)		dison	
Mar d 2 sho	7 Is m treum		19a. Informant's Name/Relationship (Туре, Kenneth F. Easter /	Print) Grandson		ng Address <i>(Street a</i> Southwel			,		•
re, N	item 2 other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place		Date		cation - City or T	
Baltimore, Permit. Pages 1 an	tent: If jury or		1 X Burial 2 ☐ Cremation 3 ☐ Rem 14 ☐ Donation 5 ☐ Other (Specify)	oval from State	reland	Memorial	Park 9-			timore,	Maryland
Balti permit.	any in		21. Signature Funeral Service Licenses	ne L	22	Name and Address MCCOMAS F 1317 COKE	suneral Hesbury Ro	ome, P. ad, Abi	A. ngdor	n, Maryl	and 21009
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death ause on each line.							Approximate Interval Between Onset and Death
	sician Iedical		Immediate Cause (Final disease or condition resulting in death)	Preum (1004
	aminer		Sequentially list conditions, b. =	Due to (or as a conseq	derice or).						
, B	ısıt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c.	Due to (or as a conseq	uence of):						
8760, A sate be executed	physician and s the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):						
876 (physicia the bu	dical	d								
Box 6	O G	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregna	ancy	7			2	23d. Date of deliv	өгу
ev_{r} \mathcal{C}_{HHA} \mathcal{M} , of Vital Records, P.O. Box 6 Physicien: The law requires that the death certific	ed by the attendir detached for use	Completed by Physician/Me	in the past 12 months? 1 □ Yes 23 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		JEctopic pregnancy Other (specify)			4	Month	Day Year
P.O.	ed by t detach	/ Phy	9 □ Unknowň Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Easter, Cana Division of Vital Records, In Attending Physicien: The law requires	s been signed b	ed b	Alzheimer's D	ementia				1 🗆	Yes 2	ÓNo 3□Pro	bably 4 Unknown
ecc lawre	2 (1	nplet						24a. Was			opsy findings available empletion of cause of
tal F	certificate has rector, page 2	e Col	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	2. No	1 Yes	2□ No
of Vil	nis cert I direct	To B	examiner? 1 ☐ Yes No Hos	oital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	00			3 □Other (Speci	fy)
on o	h. After the	:lon:	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury	y occurred	
VISION Attending	ector: by the	Certification;	2 Suiside 6 Could not be	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str		103 2	28f. Location	(Street and	d Number or Rur	al Route Number,
Div	within 24 nous arter loads. To the Funerel Director: After this certificate he completely filled in by the funeral director, page										
e Hos	e Fundietely f	Medical	29a. Certifier (Check only one) 2 Medical Examiner	an: To the best of my knoOn the basis of examina and manner stated.	ition and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	date and	place, and due t	stated. to the cause(s)
To the	To th comp	Me	29b. Signature and title of certifier			29c. Licenso				e signed (Month,	
	16		30. Name and a dress of person who comp	leted cause of death (Iten		Print)	4652 41 Air	40	/	1 414	14
	9		Scott /dusw//	2 North 32. Registrar's Signa		inut B	Al Air	Mary	1/11/1	1 0/0	7
	Sta Registr		SEP 0 9 2005	63	is A	and I		•			
				The state of the state of	and the						

			For State			ınd / Dep		Health and M	Лental Hygi	ene _{9. No.} 2005	201	436
	6		Registrar 1. Decedent's Name (First, Middle,	Last)			Timouto or	Death	2. Date of Death)	3. Time of	
	Physici		CLARE N. EVAN	S					Month SEPTEMBER	3. 2005	6:00	P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and nun	nber)		4b. City, Town, o	or Location of Death		4c. County of Deat		
		٠	Montgomery Hospice	Casey Hous	se		Rockv			Montg	omery	
	Funeral			- 75	7. Age (In yı 95	s. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day, July 5, 1	Year) 9. Birt	hplace (State o	r Foreign
	Director	ļ	219-48-5994 Usual Residence of Decedent		93	113.		1	July 5, 1	910 Pen	nsÿ1van	ia
	yland		10a. State 10b. County		10c.	City, Town or I	ocation				10d. Inside Cit	ly Limits
	Mar a-f st	ctor	Maryland Montgo	omery	B	ethesd	a				1 ☐ Yes	2 X No
	ith the	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?	
	ath w	rai	7902 Sleaford P				208			nited Star		
	ter de Item	Funerai	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Dece Armed For d 1 ☐ Yes	ces?	U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White		
980	urs af	by	3 ₩ Widowed 4 Divorced	If Yes, Give	8		1 ☐ Yes 2X No	Specify:		Specify: Wh	ite	
2-0	be filed within 72 hours after death with the Maryland nta! Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examinat must be notified at	Completed	15. Decedent's (Specify only highest			16a. Dec	edent's Usual Occup	pation	ring 1	6b. Kind of Business/	Industry	
2	within ene. than "	mpie	Elementary/Secondary (0-12)	College (1-	4or 5+)			during most of work d)	arry .	0		
22	e filed within al Hygiene. I other than vent, the Me		12 17. Father's Name (First, Middle, La	act)		П	omemaker	19 Mother's Nam	e (First, Middle, M	Own Home	9	
and	d be f ental l red or c eve	o Be	William Mc						Devaney	aloen Sumame)		
Maryland 21215-0036	2 should be and Mental Is marked aumatic ev	2	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mai	ling Address (Street	and Number or Rur	al Route Number,	City or Town, State, 2	lip Code)	
	and 2 alth a 127 is er tra		Dale E. Moore/d	aughter		119	10 Hitchi	ng Post I	ane, Roc	kville, MI	20852	<u>></u>
ore	es 1 a of He of He fitem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from 9	20b	. Place of Disp cemetery, cri	osition (Name of ematory or other pla	ce) Sonton	Date 2.	Oc. Location - City or	Town, State	
ij	Pag ment ant: I		'4 □ Donation 5 □ Other (Spe		nate	_	eaven Cemet	pepter		ilver Spring	, Maryla	nd
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic elege.		21. Signature of Funeral Service Li	Punghel	M01	173 R	2. Name and Address obert A. Pu 557 Wiscons	ess of Facility Imphrey Fundani In Avenue,	eral Home, Bethesda,	Bethesda-Che Maryland	yy Chase 20814	, Inc
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that can't one cause on ea	sed the de ch line.	ath. Do not e	nter the mode of dyin	ng, such as cardiac	or respiratory arres	st.	Approximate Interval Betw	veen
	Physician	W	Immediate Cause (Final disease or condition resulting in death)	a. Chro	nic De	bility					Onset and D	еап
	/Medical Examiner		roodking in death)			equence of):						
	284	er	Sequentially list conditions, if any, leading to immediate			Dement equence of):	1a					
10	ate be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
, 092	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (d	or as a conse	equence of):						
876	icate b physic s the bu	dicai		d								
x 68	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outo	ome of pred	nancy						
Вох	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bi	rth 2 Fe	tal death 3	☐Ectopic pregnancy ☐ Other (specify)	1		23d. Date of deli Month		ear
0	that the deatl ed by the atte detached for	hysi	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9□ Unkno		acati, o						
σ,	requires that the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to de-	ath but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of de	ath?
rds	w require been sig should b								1 ☐ Yes	2XINo 3□Pro	obably 4 ∐Ui	nknown
Records,	S D S	Completed							24a. Was an autopsy	24b. Were au	topsy findings a ompletion of ca	vailable
= H		Con							performe	d? death?	2□ No	000 0
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			nt 3 DOA Oth	ar.	h (Check only one)			
of		1: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 □ In 28a. Date of		ER/Outpatie	III JUDA	4 Nursing Ho	me 5 Residen 28d. Describe how		ity) Hospic	e
O	Attending r death. ector: After by the fune	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	n, Day Year)	Injury	Wor	k? Yes 2 □ No	Log. Doscribo non	injury occurred		
Division	Atter er dea ector by the	ertification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of Injury - At	home, farm, s	reet, factory, office			et and Number or Ru	ral Route Numb	er,
	tal or rs afte al Dir ed in	Cert			g, etc. (Spec				City or Town,			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying 2 Medical Expone)	Physician: To the to caminer: On the base and manner	best of my ki sis of examir er stated.	nowledge, dea nation and/or i	th occurred at the tire timestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)	
	To t Withi To tl	ž	29b. Signature and title of certifier	141	>		29c. Licens	e number	290	I. Date signed (Month	, Day, Year)	
•	2		Clust	IN			124	1218		9/4/	ク	
	"		30. Name and address of person we Charles Harrison					oad, Rock	villa Ma	arvland 2	0855	
	Sta	te	31. Date filed (Month, Day, Year)	32.	gistrar's Sign	nature	A \ -	oau, ROCK	viite, Ma	ryrand Z		
	Registr	ar	SEP 0 9	2005	Messen .	15 P	certi					

Projection CARLTON FREEMAN, SR. Facility Name of and continuous, give press and number CORD SAMARTTAHHOSPITAL SOUTH THORSE THAT IN CONTINUOUS				. For	State of Ma	ryland / Depa	artment of I	Health and	Mental Hy	giene o	חחב.	2012
CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,15 M CARLITON FREEMAN, SR. Section from of location of December 2, 2000 5,				1 - State Registrar		Cei	tificate of	Death		Heg. No.		2943
## Facility Name of Free considering to the area on number ## County Manufacture of Land County of Date of Section 1 10 10 10 10 10 10 10									Month	Day	rear	
Second Second Personnel Colored Technology Co							4b. City, Town,	or Location of Deat				5 5,45
The state of the s				GOOD SAMARITAN					9 Date of Rig			- (C+++
Use The Engineering To General Control of				1□]M 2□F	Yrs.			(Month, Da		M)
THE NATION OF THE CONTROL AND ADDRESS AND THE CONTROL AND ADDRESS		and w					cation		JANUA	RY 13,	, 1935	
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THE NATION OF THE CONTROL AND ADDRESS AND THE CONTROL AND ADDRESS		vith the	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Country	?
THE NATION OF THE CONTROL AND ADDRESS AND THE CONTROL AND ADDRESS		Jeath v	erai		12. Was Decedent E	ver in U.S. 13.	Was Decedent of I	lispanic Origin? (S	Specify Yes or No	- 14. R		A Indian,
PROPERTY OF A STATE OF THE CONTROL AND A STATE OF THE STA	9	or Ite	y Fur		1 ∏ Yes 2 □ N If Wes, Give	°7/24/195	f Yes, specify Cub 12⊡ Yes 2√⊡ No	an, Mexican, Puer Specify:	to Rican, etc.)			
THE NATION OF THE CONTROL AND ADDRESS AND THE CONTROL AND ADDRESS	Ö	2 hours	ted b	15. Decedent's Edu	cation	8/10/195 16a. Deced	5 ient's Usual Occup	pation			Br	
THE NATION OF THE CONTROL AND ADDRESS AND THE CONTROL AND ADDRESS	215	ithin 7. ne. nen "n	nple	Elementary/Secondary (0-12)		life	kind of work done DO NOT use retire	during most of wo	rking			•
Secretarian Company		Hygier Hygier other th			UNKNOWN	SECU	RITY GU		me (First, Middle,			
Secretarian Company	<u>lan</u>	uld be Mental rrked c	To B		TT FREEM	AN, SR.		BESSIE	ELIZA	ветн к	EYES I	FREEMAN
Secretarian Company	Man	12 sho h and I 7 Is mu treumu			рө, Print) DAU	GHTER 19b. Mailir	ng Address (Street	and Number or Ri	ural Route Numb	er, City or Town	n, State, Zip Co	ode)
Secretarian Company		s 1 and f Healt item 2		20a. Method of Disposition					Date / o =	20c. Location	- City or Town	State
23a Part, Effer the disease, crossfelications traceuple death. Do not enter the mode of dying, such as cardad or respiratory arest. Sale part, Effer the disease, crossfelications traceuple and early property of the disease, crossfelications traceuple and early property of the disease, crossfelications traceuple and early property of the disease, crossfelications traceuple and early property of the disease, crossfelications traceuple and early property of the disease of the death. Do not enter the node of dying, such as cardad or respiratory arest. Card of the disease, crossfelications traceuple and early property of the disease of the death. Do not enter the node of dying, such as cardad or respiratory arest. Card of the disease of the death. Card of the disease of the disease of the death. Card of the disease of the disease of the di	Ë	Page ment o ent: If ury or		' 4 Donation 5 Other (Specify)		GARRISI	N FORES	T VET.	CEM.	OWINGS	MILLS	5, MD.
23a Part Effects a desease of Portplications that duple the death. Do not enter the model of dying, such as cardad or respiratory areas. Approximate the models cause (Final disease or condition as a consequence of): Lay Model and Barbins and Cheath Medical Examination Freshills is conditions. Sequentially is conditions. Sequenti	Balt	permit. Depart Import any inj		21. Signature of the eral Service Licens	ÎS T, GW	YNN L	EWIS T.	GWYNN			21215	5-6393
The Color of the control of the cont				23a. Part1. Enter the disease, or compliant the control of heart failure. List only or	cations that caused	the death. Do not ent	517 PAR or the mode of dyi	K HEIGH ng, such as cardia	TS AVE	NUE B	A	MD pproximate
Security in teaching in teach Security in teach Security in teach Security in teach Security in teach Security in teach Security in the finite of earth Security Sec	Į,			Immediate Cause (Final disease or condition	Laryng	leal Can	cer				Öi	nset and Death
Due to (or as a consequence of): Compared by the compared of the control of th				resulting in death)	Due to or as a	consequence of):	Duell	MANAIA				
Section Sect		p ≅	ner	cause. Enter Underwind	Due to or as a		. 1 /	100010				
Section Sect	•	xecute and al-trans	xam	that initiated events	Due to (or as a	-0114	mbol	19W				
FFEMALE: 23c. If yes, outcome of programing 23d. Date of delivery 1 1 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 1 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 1 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 1 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 2 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 2 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 2 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 2 vs birth 2 Fetal death 5 Other (specify) 23d. Date of delivery Month Day Year 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2 Fetal death 5 Other (specify) 2 vs birth 2	1260	ite be e iysiciar ne burii	cal		ı							
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The part of the completion of cause of death of the cause of death	Bo	death of attention of for us	ician	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3		у				y Year
24a. Was an autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 25 Was case referred to medical examiner? 25 Was case referred to medical examiner? 26 Place of Death (Check only one) 27. Manney of Death 27. Manney of Death 28b. Death 2	<u>О</u>	d by the	Phys	9 Unknown		t ant roculting in the	- d k d	on in Doubl	22a Did t	abassa usa sa	atsibuto ta tho a	augo of doub?
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 5 Pending investigation 2 Page Place of Injury - At home, farm, street, factory, office 2 P	ds,	uires II signe IId be d		Patti. Other significant conditions con	ithouting to death bu	t not resulting in the di	idenying cause gr	ven in ranti.				
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 29a) (Type, Print) 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	0	ing Ph Viter th uneral	on: 1				Wo	ry at rk?				
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrar's Signature	/isio	Attend death octor: /	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At home, farm, str		Yes 2 □ No			aber or Rural Ro	oute Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Full And State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	á	itel or after rel Dire	Cert	4 Hottlicide								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Full And State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hosp 24 hou Fune etely fil	dical	Check only 2 Medical Exemit	ter: On the basis of	examination and/or inv	occurred at the ti restigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and m date and place	nanner as state , and due to the	d. e cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hairmore, MD 2/239 State State Registrar 31. Date filled (Month, Day, Year) 32. Registrar's Signature		To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ed (Month, Day	r, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hairing Liaug 5601 Loch Raven Blvd, Baltimore, MD 2/239 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		. \) (400 h	7 . 1	UNUM	1KE.	2000		DYIO	6/ 202	2
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		DX/		Hairland Llaug	5601 Lo	ath (Item 23a) (Type, Ch Ra Veh	Blud, B	altimor	e, Mi	0 2/	239	
				31. Date filed (Month, Day, Year) SEP 0 9 2005	32 Registra	's Signature	de la					

			1 - For Stata Registrar	State of I	Maryland / Do	eparti C <i>ertif</i>	ment of Heicate of L	ealth and M Death	dental Hygi	ene 2005	29438
П	Physic	ian	1. Decedent's Name (First, Middle, La	•					2. Date of Death		3. Time of Death
	/Medi		Gisela Ebert Flei						Septembe	er 09,2005	12:10A. M
1	Examir	ner	4a. Facility Name (If not institution, gir	e street and numbe	er)	4b	-	Location of Death		4c. County of Deat	
			Broadmead 5. Social Security Number 6.	Sex 7.	Age (In yrs. last birth	daus) If	Under 1 Year	eysville If Under 24 Hrs.	0.0	Baltimore	
	Funeral Director			1□M 2ĬF	84 Yr	Mo	onths Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	nplace (State or Foreign untry)
	D		Usual Residence of Decedent		04				March Zz	2,1921 nami	ourg, Germany
	how	_	10a. State 10b. County		10c. City, Town of	or Location	on				10d. Inside City Limits
	Be-f s	cto	Maryland Baltimo	re County	Cockey	svil	le				1 ☐ Yes 2Ã No
	or 2	Dire	10e. Street and Number			1	Of. Zip Code		10	g. Citizen of What Co	untry?
	s 23e	Funeral Directo	13801 York Road	1			210			United Sta	ates
	item item	E.	11. Marital Status	12. Was Deceder	s?	13. Was If Ye	Decedent of His s, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
336	irs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give Year or Dates		1 🗆 '	Yes 21 No	Specify:		Specify: W	nite
21215-0036	72 hours after death with the Maryland "natural", or items 23e or 28e-f show cited Examiner must be nutified at	ted	15. Decedent's E	ducation		ecedent's	s Usual Occupat	tion	1	6b. Kind of Business/l	
215	within 7. iene. than "n	ple	(Specify only highest grade) Elementary/Secondary (0-12)	ade completed) College (1-4o	(0	Give kind		uring most of work	ing	ob. Raid of Edulies Sal	ildustry
2	filed withir Hygiene. sther than ant, Itiu M.	Completed	12	08	. 547	P	sychiati	rist		Psychi	latry
pu	d a b w	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	, , , , , , , , , , , , , , , , , , , ,		
Maryland		2	Karl Ebert					Clara Has			
Jar	O 00 00	0.1	19a. Informant's Name/Relationship (• • • •						City or Town, State, Z	
6,	s 1 and 2 f Health item 27 i	1	Dr. Esther M. Flei	schmann(D			2 Ken Oa		-	re, Maryla	
Baltimore,	\$ = 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from Stat	20b. Place of D cemetery,	cremator cremator	Name of ry or other place	1 0		Oc. Location - City or 1	
計	permit. Pa Departmer Importent eny injury		'4 □ Donation 5 □ Other (Special	• •	Evans Fi			el Sept.(1,Maryland
Ba	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Service Lice	7. yau		eac. 2325	eful Adri York Ro	ternative oad Timo	s Funera nium, Ma	1&Crematic ryland 21	on Ctr.,P.A.
Г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. Do not line.	enter the	mode of dying,	, such as cardiac o	or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	STR	OK	E				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	20	_			,	
		<u>_</u>	Sequentially list conditions,	b. Due to (or a	s a consequence of):	ML	- 1-1	BRIL	-LATI	ON	3 mo.
T	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0 10 10 10 10	HUPLA	2 T	-415	101/			
, ,	ficate be executed physician and s the burial-transit	Еха	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):	1	UIVS.	1010			
68760,	re be ysicia e bur	edical	· ·	d							
	tificat ng phy as th	led									
Вох	that the death certil ed by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		2 🗆 Eato	pic pregnancy			23d. Date of deliv	ery
	ed fo	slcia	in the past 12 months?				er (specify)			Month	Day Year
P.O.	at the	Phy	9 Unknown								
	iaw requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions of	ontributing to death	but not resulting in th	e underly	ving cause given	in Part I.	ale:	cco use contribute to	
orc	requi	eted	Papillary	mucin	503 M	OPIC	>3m of	t parax	1 Tes	2 □ No 3 🖫 Pro	bably 4 Unknown
Sec	has b	Completed	'COPD-U			U .			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
<u>E</u>	: The cate ha	Co			_				performe	d? death? No 1 ☐ Yes	
Vital Records,	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death	(Check only one)		
	Phys	T.	1 ☐ Yes 2 TNo 27. Manner of Death	1 ☐ Inpat			DOA Other:	4 Mursing Hon		e 6 □Other (Speci	5y)
on	ding I h. After funer	to Li	1 ENatural 5 ☐ Pending	(Month, D	ay Year) 266. 11mi		28c. Injury a Work? 1 ☐ Ye		8d. Describe how	injury occurred	
Division of	after deatl Director: in by the	flca	3 Suicide 6 Could not be		njury - At home, farm,				9f Location (Stre.	et and Number or Run	of Pouto Number
Ö	after i Dire d in b	Certification;	4 Homicide determined	building, e	itc. (Specify)	otroot, it	actory, cirico		City or Town,	State)	ar noble realider,
	pspite hours unere y fille	alc	29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowledge, de	eath occu	ırred at the time,	, date and place, a	nd due to the cau	se(s) and manner as s	tated.
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exam	niner: On the basis and manner s	or examination and/oi	r investig	ation, in my opin	nion, death occurre	d at the time, date	e and place, and due to	the cause(s)
	With Com	≥	29b. Signature and title of certifier	P	11/2	20	29c. License r	number	29d	. Date signed (Month,	Day, Year)
)			Darvara	- Carr	all //	4	D3	8390	4	9/9/2	005
	20		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	pe, Print)		1		1111	
			DAK BAKA C	KKOLL	M.D.	/3	801 Y	ORK	RD., C	OCKEYSL	ILLE, MID
•	Sta Registra		31. Date filed (Month, Day, Year) SEP () 9	19	rár's Signature	B	/		/	•	
			OLF U 9	2005	diana Br	Rose	elle d				

12:10 AM

GISELA FLEISCHMANN

			1 - For State Registrar	State of M	arylanc	l / Depa <i>Cei</i>	artment of I	lealth a	and Mer	ntal Hyg	jiene _{leg. No.} 2	005	29439
	Physici		1. Decedent's Name (First, Middle Rosella	, Last) Fenner						Date of Dea Month) 9	th Day 06	Year 05	3. Time of Death 17:30P M
	/Medic Examin		4a. Facility Name (If not institution	-)		4b. City, Town, o	_	of Death			unty of Death	
ř	Funeral Director		Prince George 5. Social Security Number 240-14-3699	6. Sex 7. Ag	ge (In yrs. la	st birthday) Yrs.	Chever If Under 1 Year Months Days	If Under	24 Hrs. 8. Min. 0	Date of Birth (Month, Day 7-01-0	Pri: , _{Year)} 9		orge's lace (State or Foreign try) eld, NC.
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation						Od. Inside City Limits
	he Mary 28a-f sh otified	ector	MD Prince	Georges	La	nham	104 7% Code				12- 611	-614/1	1X Yes 2 No
	h with t	Di	3208 Reed Stree	et #2522			10f. Zip Code 20706				USA	of What Cour	ury ?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumetic event, the Medical Exatt har must be notified at ODGe.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marr 3 ☼ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	?	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No			Yes or No- an, etc.)		Race - Americ Black, White, ecify: B1a	etc.
21215-0036	ithin 72 hou ne. nen "neture nedical E	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)		5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos	t of working			of Business/Ind	dustry
d 21	filed w Hygier other th	e Cor	0 17. Father's Name (First, Middle,	Last)		Но	memaker	18. Mothe	er's Name (Fi	rst, Middle,	Priv Maiden Sun		
Maryland	Mental Mental arked c	To Be	Unknown						ie Mc				
Mar	nd 2 sho lith and 27 is m treum		19a. Informant's Name/Relations Victoria Brisc				ng Address <i>(Street</i> Reed Str						,
ore,	es 1 ar of Hea if item		20a. Method of Disposition 1 → Burial 2 □ Cremation		cei	ace of Dispo metery, crer	sition (Name of matory or other pla	ce)	Date		20c. Location	on - City or To	wn, State
altimore,	artment artment ortent: injury c		4 □ Donation 5 □ Other (S_i21. Signature of Funeral Service	pecify)	Sou		W Cemeter 2. Name and Addre		0-10-05			lin, VA	
Ba	Department of the permitted of the permi	1	& p ma	chall			217 9th.						
	Physician /Medical Examiner	Examiner	23a. Party Eriber the disease, or shook, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause. Enter underlying cause. Unservice of the cause of which is the cause of the cause of the cause.	only one cause on each l	ine. LLLP a conseque	11 0 / ence of):		ng, such as	cardiac or re	spiratory arr	est,		Approximate Interval Batween Onset and Death
68760,	death certificate be executed e attending physician and xd for use as the burial-transit		that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):							
P.O. Box (ihat the death certifics ed by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnanc Other (specify)	у				Date of delive Month	ry Day Year
	sign sign d be	by	Part II. Other significant condition Multiple	1	SUFE	-	nderlying cause gin	ven in Part I.		23e. Did to	_/		e cause of death? ably 4 □Unknown
Vital Records,	The ate h page	Completed	Respir	atory i	n Sc	in for	'Ci'Cn	Cy.		24a. Was a autops perform 1 ☐ Yes	sy	prior to cor death?	osy findings available inpletion of cause of
o	To the Hospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, page	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin investig	jation	ury 2	R/Outpatien 28b. Time of Injury	28c. Inju	ner: 4□ Nu ryat	28d.		ence 6 🗆 (Other <i>(Specif</i>) curred	")
Division	iel or Atte s after de sl Directo	Certification;	3 Suicide 6 Could in determined	ined 286. Place of in	jury - At hon tc. (Specify)	ne, farm, str	eet, factory, office			Location (Si City of Town		ımber o <i>r Rur</i> a	Route Number,
	To the Hospitel or Attenc within 24 hours after dealt To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner st	of examination	rledge, death on and/or in	n occurred at the ti vestigation, in my	me, date an opinion, dea	d place, and th occurred a	due to the c	ause(s) and ate and plac	manner as st ce, and due to	ated. the cause(s)
)	To t with To t	Σ	29b. Signature and title of certifie	S. Amer	re.	Mi	29c. Licens	se number くってん	52	2	9d. Date sig	gned (Month, I	Day, Year)
	. *		30. Name and address of person	who completed cause of	death (Item :	23a) (Type,	Print) ALC	ese	5.	Im	iru	00	
	10		7202 Q U 31. Date filed (Month, Day Year)	ISIN SET	rar's Signati	Jay	Bo	Wic		MI	2	072	0
	Sta Registr		SEP (9 2005	ENS.	JOS OF	GOBALL .						

	an	Decedent's Name (First	r, Middie, La		ie Ailee	n Foy					2. Date of E Month	Day	y 9	Year 200!	3. Time of Death 2:58
/Medic		4a. Facility Name (If not in	stitution, gi			JII I OX		Town, or	Location (of Death	40303			of Death	2:50
LACITIII		815WINTER	S LAN	E			CAT	ONSV	ILLE				BAI	LTIMO	RE
Funeral Director		5. Social Security Number		Sex 7 1 □ M 2 □ F	7. Age (In yrs. 6		If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Birth Day, Year)		9. Birthp Cour	lace (State or Foreigntry)
Mector		219-42-9347 Usual Residence of Dece		^		02					June 2	9, 194	3		Virginia
show	_	10a. State 10b.	County		10c. Cit	ty, Town or Lo	ocation							1	0d. Inside City Limit
or 28a-f show e notified at	Director	Maryland 10e. Street and Number	Ba	altimore			10f. Zip		atonsvil	lle		100 0	izon of l	What Cour	1 ☐ Yes 2√ N
23a or	i Dir	815 Winters L	ane An	t #118			101. 21	Code	212	228		log. Cit	12011 01 1	U.S.	*
ams 2	Funeral	11. Marital Status	ano Ap	12. Was Deced		.S. 13.	Was Dece	dent of Hi			ecify Yes or I	10-		e - Americ	an Indian,
l Health and Mental Hygiene. Itam 27 ia marked other than "natural", or Itams 23a or 28a-f sho other traumatic avant, The Medical Evanimer must be notified at	by Fu	1 Never Married 2		1 Tes 2 If Yes, Give Year or Da	2 XN0		1 ☐ Yes		Specify:		riloan, oto.)		Specify		61C.
"natural", edical Exa	ted	15. D	ecedent's E	Education		16a. Dece	dent's Usua	al Occupa	ation			16b. K	ind of B	usiness/Inc	dustry
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f itam r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crer	n		20b. P	Place of Disponentery, cre-	osition (Name	me of other plac	e)		Date	20c. Lo	ocation -	City or To	own, State
tant: I		`4 □Donation 5 □ C	ther (Speci	ify)		County C	rematic	n Sen	vices Ir	09/0	06/2005		Syk	esville,	Maryland
Department of Health a Important: if itam 27 is any injury or other traisonce.		21. Signature of Funeral S	Service L	nsee	i	2	2. Name ar		ss of Facilit uneral	•	РΔ				
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			For State Registrar	State of Mar	yland / D	epai <i>Cert</i>	rtment of H ificate of L	lealth and Death	Mental Hy	giene Reg. No	2005	29441
	Physici	an	Decedent's Name (First, Middle, La VEVIAN D. FOV.	st)					2. Date of De Month	Da	ıy Year	3. Time of Death
	/Medic	al	KEVIN P. FOX 4a. Facility Name (If not institution, giv	o street and symbol			4b. City, Town, or	Location of Dec	SEPTEMB	-	2005 County of Death	5:45 P. M
	Examin	er	201 PATUXENT ROAD	e street and number)			LAUREL	Location of Dea	iu i		PRINCE GEO	RGE
	Funeral Director		5. Social Security Number 6. S 073-44-1638	VI M OFF	In yrs. last birti	rhday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Mir		rth ay, Year) 1954	9. Birthp Cour	place (State or Foreign htry)
	and		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town	orloc	ation					0d. Inside City Limits
	Maryla -f sho	tor		GEORGE	LAUREL						ľ	1X□Yes 2□No
	h the	Director	10e. Street and Number	deonde	LAONEL		10f. Zip Code			10g. Cit	tizen of What Cour	ntry?
	ath wit	ralD	201 PATUXENT ROAD				20707			U	JSA	
36	be filed within 72 hours after death with the Maryland ital hygiene. In the maturel, or items 23e or 28e-f show event, the Moderal Examination in the Moderal Examination is at the collined at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	lf 1	as Decedent of Hi Yes, specify Cuba □ Yes 2⊠ No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: W	
2-0036	'2 hou	ted	15. Decedent's E.	ducation	16a.	Decede	nt's Usual Occupa	ation	netrin n	16b. K	(ind of Business/In	dustry
2121	C * 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. Do	O NOT use retired)	Jiking			
d 21	filed w Hygiei other tl	e Co	12 17. Father's Name (First, Middle, Last,	Ø	M	IASTE	R CARPENTE		ame (First, Middle	1	ARPENTRY Surname)	
an		To B	LEONARD FOX, SR.					MARIA	A. FRANGEL	LA	,	
Maryland			19a. Informant's Name/Relationship (Type, Print)		-					or Town, State, Zip	Code)
	1 and Health em 27		MARSHA FOX / WIFE 20a. Method of Disposition		20b. Place of		PATUXENT R	OAD, LAUR	EL, MARYLA Date		0707 ocation - City or To	num Stata
altimore,		0.0	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	cemetery BALT/WAS	y, crema	tory or other plac	. !	/12/2005		AUREL, MAR	
Ball	permit. Page Department of Importent: If eny injury or once.		21. Signarure of Juneral Service Lice	NV -			Name and Addres	S of Facility F	LECK FUNE , LAUREL,	RAL H	OME, INC. LAND 20707	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a	rull	دو	the mode of dying	g, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c								
8760,	ficate be executed physician and is the burial-transit	edical E		Due to (or as a c)); 						
ၑ	certific Iding p		IF FEMALE:	23c. If yes, outcome of	pregnancy				11.11.1		23d. Date of delive	
.O. Box	The law requires that the death certificate to has been signed by the attending physbage 2 should be detached for use as the	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 [4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death		ctopic pregnancy Other (specify)				Month Month	Day Year
о.	res that igned b be deta	by Pr	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the und	lerlying cause give	en in Part I.	23e. Did	tobacco i	use contribute to th	ne cause of death?
ord	w require been sig should b								1 🗆	Yes 2	□No 3□Prob	ably 4 Dunknown
I Records,	The law rate has be page 2 sh	Completed				-			24a. Was auto perfo	psy ormed?	prior to cor death?	psy findings available inptetion of cause of
Vital	ysician: The is certificate h	Be	25. Was case referred to medical examiner?	Hospital:			Othe	\C	eath (Check only			
ot	Phys r this aral dir	7: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Out 28b. Ti		3 □ DOA Othe 28c. Injury Work	4 🗀 Nursing	Home 5 6esi 28d. Describe		6 ☐Other (Specify rv occurred	/)
lon	nding lath. r: After e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ea <i>r)</i> In	njury		t? Yes 2 □ No			.,	
Division of	or Atterdes Directo in by th	Certification:	3 🗍 Suicide 6 🗎 Could not b 4 🗍 Homicide determined	28e. Place of Injury building, etc. (- At home, fan (Specify)	m, stree	et, factory, office		28f. Location (City or To	Street an wn, State	nd Number or Rura a)	l Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical Ce	29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exar	ysician: To the best of r niner: On the basis of ex and manner stated	camination and	, death of	occurred at the tim stigation, in my op	e, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s)) and manner as st d place, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1			29c. License			29d. Da	te signed (Month,	Day, Year)
1			• () ()	di			200	31040		00	107/0.	5
	20		30. Name and address of person who	0 1	th (Item 23a) (Туре, Р	rint)	king Ho	rolal			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9	32. Registrar's	Signature	,						
			SEF U S	LUUU Flere	in the	_	SORATE A					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

hysiciaı		1. Decedent's Nam				=	1	1/		2. Date of De	Dey	Year	72 <i>00</i>
/Medica	al –	4a. Facility Name (If not institution	Son rive	street and nu	mher)	LEEL	\	4b. City. Town, o	or Location of Deat			1200
xamine		WESTER				NALIA	USTITU	TION	_	ERLAN	,	LECA	wy
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ector		212-60-8	399	1 🔯	M 2□F	52	Yrs.	Months Da	ays Hours M	8. Date of Bi in. 4—3—1	953	9. Birthplace <i>Country)</i> Mary Lai	nd
	- 1	Usual Residence o	f Decedent 10b. Count			100.0	City Town or I	costion				104	Incido City I
Lottlied at	.	10a. State	Balti	-			City, Town or L	ocation					Inside City Li 1 ☐ Yes 2€
	ect C	MD 10e. Street and Nu		.mor e	:	l I	I/A	10f. Zip Cod	4		10g. Citizen of		
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ğ	by Fur	11. Marital Status 1 Never Mari 3 Widowed	ried 2⊠ Ma	ırried		2 ∑No ve	U,S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Ne erto Rican, etc.)	0- 14. Rac Blac	ce - American I ck, White, etc. y: White	
ies i	<u>8</u>	/0	15. Decede	nt's Edu	cation		16a. Dece	edent's Usual Do	ccupation	un dein n	16b. Kind of B	usiness/Indust	try
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traumatic		19a. Informant's N Mary A.					19b. Mail 6536	ing Address (St. St. He	reet and Number or lena Ave.	Rural Route Numb Baltimo	per, City or Town, re MD 21	State, Zip Co 222	de)
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DHMH 16 Rev 6/95

Stanley Charles Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)	24 Hrs. 8. Date of Birth (Month, Day 28) 1 igin? (Specify Yes or Non, Puerto Rican, etc.) st of working er's Name (First, Middle, Namet Prate	Og. Citizen of What Cour USA 14. Race - Americ Black, White, Specify: W Construct Maiden Sumame)	can Indian, etc. Thite dustry
Examiner 4a. Facility Name (If not institution, give street and number) Wivexity of Mayland Medical Center 5. Social Security Number 263-85-2294 Usual Residence of Decedent 4b. City, Town, or Location BALTI MORE BALTI MORE 47. Age (In yrs. last birthday) 42 Yrs. 42 Yrs.	of Death 24 Hrs. 8. Date of Birth Min. May 28 1 1 1 1 1 1 1 1 1 1 1 1 1	4c. County of Death NA 9. Birthy Cour USA 14. Race - Americ Black, White, Specify: W 16b. Kind of Business/Inc Construct Maiden Sumame)	place (State or Foreigntry) MD 10d. Inside City Limit: 1 ☑ Yes 2 □ Nontry? can Indian, etc. thite dustry
Director 263-85-2294 1 X M 2 F 42 Yrs. Months Days Hours Usual Residence of Decedent	Min. Month, Day May 28 1 1 1 1 1 1 1 1 1 1 1 1 1	Og. Citizen of What Cour USA 14. Race - Americ Black, White, Specify: W 16b. Kind of Business/Inc Construct Maiden Sumame)	MD 10d. Inside City Limit. 1 ⊠ Yes 2 □ Nontry? can Indian, etc. Ihite dustry
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10e. Street and Number 24030 Custis Neck Road 2330'	1 igin? (Specify Yes or No- n, Puerto Rican, etc.) st of working er's Name (First, Middle, A anet Prate er or Rural Route Number,	USA 14. Race - Americ Black, White, Specify: W 16b. Kind of Business/Inc Construct Maiden Sumame)	can Indian, etc. Thite dustry
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexical 1 Yes, Give Year or Dates: 10. Per Part Yes, Give Year or Dates: 10. Per Part Yes, Give Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired) 16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother Stanley Charles Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Danet Prato Finch—Bahel (mother) P0 Box 691 240.	er's Name (First, Middle, A anet Prate er or Aural Aoute Number,	Black, White, Specify: W 16b. Kind of Business/Ind Construct: Maiden Sumame)	etc. Ihite dustry
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8 Contractor 17. Father's Name (First, Middle, Last) Stanley Charles Finch 19a. Informant's Name/Relationship (Type, Print) Janet Prato Finch—Bahel (mother) PO Box 691 240:	anet Prate er or Rural Route Number,	Ma <i>iden Sum</i> ame) O	ion
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number) 2 E E C C C C C C C C C C C C C C C C C	er or Rural Route Number,		
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature 1 Fuperal Sarvice Lider is 22. Name and Address of Facility 3111 Mountain R	2005 T	20c. Location - City or To Femperancevi	lle, VA
21. Signature of Funeral Service Lider se 22. Name and Address of Facility 3111 Mountain R 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or hear failing. List only one cause on each line. Physician Covordad Oversal Classes or condition	cardiac or respiratory arre	a, MD 21122	Approximate Interval Between Onset and Death
Sequentially list conditions. Sequentially list conditions Sequentially list cause Seq			
The continue of the continue		23d. Date of delive Month	ery Day Year
The state of the s		pacco use contribute to the	
Completed	24a. Was ar autopsy perform 1 Yes 2	v prior to cor	psy findings availab npletion of cause of 2 No
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nu	of Death Check only one or one of Death Check only one	-	
25. Was case referred to medical examiner? 1 Yes No	28d. Describe hor		<i>n</i>
28a. Date of Injury 28b. Time of Injury at Work? 28c. Injury at W	City or Town,	•	
29a. Certifier Check only one) 29b. Signature and title of certifier 29c. License number.	d place, and due to the ca th occurred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
29b. Signature and title of certifier 29c. License number P17 167		Deptember 07	
Evonne Fontamila da South Greene St State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltimore	MD 2120	oi
Registrar SEP 0 9 2005			

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of tificate of	Health and N Death	lental Hyg	Reg. No.	15 29444
ı	Physici /Medic		Decedent's Name (First, Middle, Last William	Villis O.	Freitag			2. Date of Dea Month Septemb	per 5, 200	
7	Examin Funeral		4a. Facility Name (If not institution, give 3308 Solomons Co 5. Social Security Number 6. Se	urt	n yrs. last birthday)	Silver		8. Date of Birt	4c. County of D Montgom	ery Birthplace (State or Foreign
	Director		550-05-2850	QM 2□F 93	3 Yrs.	Months Days	Hours Min.	(Month, Da August	(4, 1912 Ca	alifornia
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Directo	10e. Street and Number			10f. Zip Code	20906		10g. Citizen of Wha	•
136	be filed within 72 hours after deeth with the Maryland tal Hygiene d other then "naturel", or items 23a or 28s-f ehow event, the Madical Examinar must be nutilies.	by Funerai	3308 Solomons Cou	17 C 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	ŀ	Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 🔯 No	Hispanic Origin? (Sp ban, Mexican, Puerto			American Indian, Vhite, etc.
1215-0036	within 72 hou ene. then "neture he Medical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire CONIC ET	during most of work ed)	ring	16b. Kind of Busin	
and 7	d be filed vantal Hygie	Be	17. Father's Name (First, Middle, Last) Vivian Glen Freit		Птесе		18. Mother's Nam		Maiden Sumame) ne Dillon	
Maryland	2 should and Men le marke raumatic	P_C	19a. Informant's Name/Relationship (T	ype, Print)		, , ,	at and Number or Rui			te, Zip Code) ryland 20906
Baitimore, n	ages 1 and 2 should bent of Health and Ment at: If Item 27 le marked y or other traumatice		Ruth A. Freitag / 20a. Method of Disposition 1 Burial 2 Cremation 3 Di 4 Donation 5 Other (Specify	Removal from State	20b. Place of Dispo cemetery, cres Gate of Hea	esition (Name of matory or other pl	ace) Sept	Date ember	20c. Location - City	
Dail	permit. Pages 1 Depertment of H Important: If Its eny Injury or ot 2008.		21. Signature of Funeral Service Licens In Selection	500	RO RO	Name and Add	ess of Facility Imphrey Fune	ral Home/	Rockville,	
8/00,0	Physician and physician and physician and physician and physician stee the physician stee	dicai Examiner	23a. Part. Ever the disease, or comp shock, or heart failure. List only commendate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	tive Hear		_	or respiratory an	1651,	Approximate Interval Between Onset and Death
O. BOX 6	death certifi e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	f delivery Day Year
-	ires the signed d be de	Ď	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.			te to the cause of death?
al Hecords,	The law ete has b page 2 s	Completed						24a. Was autor perfo 1 Yes	osy prior rmed? deat	
on of Vital	ding Physiclan: Th n. After this certificete funeral director, pag	tion; To Be	27. Manner of Death 1 🖾 Natural 5 🗆 Pending	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	f 28c. Inj		ome 5 🖔 Resid	dence 6 Other (Specify)
Division	al or Attending s after death. Il Director: After ad in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, sti Specify)			28f. Location (: City or Tox	Street and Number o	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	Check only one) 12 Gartifying Physical Example 2 Medical Example 1	ysinian. To the best of m liner: On the basis of exa and manner stated	amination and/or in	h occurred at the vestigation, in my	twire, date and place opinion, death occur	red at the time,	cause(s) and manne date and place, and	due to the cause(s)
	To the within 2 To the complet	₹ E	29b. Signature and title of certifier Benowd A. Heck	wan. H A			nse number		29d. Date signed (N	
	H		30. Name and address of person who d		h (Item 23a) (Type,		05373		September	6, 2005
	Sta Regist	ate rar	Bernard A. Heckma 31. Date filed (Month, Day, Year)		30 Camero		t, #405, S	Silver S	pring, Ma	ryland 20910

			For State C	of Maryland / Dep <i>Ce</i>	artment of Health and	Mental Hygie	ene 2005	29445
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici: /Medic		MELVIN FREEDMA	+N		10.0	06 2005	245 PM
	Examin		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Deat		4c. County of Death	N1 / A
			LKVINDAIR HEBIEN G. 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	BACTIMU A		9 Rirthr	N/A
	Funeral Director		213-16-5454 X 12 M 2 F	86 Yrs.	Months Days Hours Min		(ear) Cour	place (State or Foreign htry) MD
	pu 🛊		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Maryla feho	o	MD BALTIMORE		TIMORE			1 ☐ Yes 2 🔀 No
	the ?	rect	10e. Street and Number	DAL	10f. Zip Code	10g	g. Citizen of What Cour	ntry?
	h with	Funeral Director	7203 ROCKLAND HILLS DR	RIVE #311	21209			USA
	ams	Iner	11. Marital Status 12. Was Dec Armed F	edent Ever in U.S. 13. orces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28e-1 ehow any injury or other traumatic event, "Itamedical Examinations must be motified at once.	by Fu	1 Never Married 2 Married 1 Yes If Yes, G 3 Widowed 4 M Divorced Year or D	2 M No ive Dates:	1 ☐ Yes 2 💢 No Specify:		Specify:	WHITE
21215-0036	2 hou	ted t	15. Decedent's Education	16a. Dece	edent's Usual Occupation e kind of work done during most of wo	16	6b. Kind of Business/In	dustry
218	thin 7 le. len "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) life.	DO NOT use retired)		UDNITUDE	
	lled w tygier her th	Co	17. Father's Name (First, Middle, Last)	SALES		me (First, Middle, Ma	URNITURE	
Maryland	d be fi	Be c	SOLOMON	FREI	EDMAN TENIE	mo (* #3t, Milabe, Ma	oden comane,	SIMMONS
ary	shoul nd Me mark	To	19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or R	ural Route Number, C	City or Town, State, Zip	Code)
	and 2 leith a n 27 is er trai		DANIEL FREEDMAN / BROT	THER 111	HAMLET HILL ROAD	#1108 - B	BALTIMORE,	MD 21210
ore	of He of He If item or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from	State	matory or other placeHEBREW		c. Location - City or To	
altimore,	t. Pag rtment rtant:		`4 ☐Donation 5 ☐ Other (Specify)	MOSES MOI	NTEFIORE WOODMOOR		HALETHO	
Ba	Deparent Deparent Important in Suny in Sunce Once		21. Signature of Funeral Service Licensee		2. Name and Address of Facility S 8900 REISTERSTOWN		N & BROS., KESVILLE.	INC. MD 21208
	÷		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not er				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	erebro vascul	an accident			Ontol and Dodin
	/Medical Examiner		Due to	(or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of):				
·	acuted ind transit	Examiner	Cause (Disease or injury that initiated events c					
60,	icate be executed physician and s the burial-transit	ai Ex	resulting in death) Last Due to	(or as a consequence of):				
68760,		edicai	d					
Box (n certii anding use a	n/Me		utcome of pregnancy birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delive	*
B.	es thet the death certific igned by the attending p be detached for use as	Physician/M	1 Yes 2 No	nant at time of death 5	Other (specify)		Month	Day Year
P.O.	het the of by t	Phy	9 Unknown Part II. Other significant conditions contributing to c	feath but not resulting in the	underlying cause given in Part I.	23e, Did toba	cco use contribute to the	he cause of death?
Division of Vital Records,	Hospital or Attanding Physicien: The law requires thet the death certif 4 hours after death. Funerel Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use a	d by	Turn, out of digital control of the			1 🗆 Yes	2 No 3 Prob	bably 4 Unknown
00	s been si	Completed				24a. Was an	24b. Were auto	psy findings available
Re	The la	mo				autopsy performe		mpletion of cause of 2 No
ital	cien: artifica	ВеС	25. Was case referred to medical examiner?		A.4	ath (Check only one)		
of V	hysic this co	ည		Inpatient 2 ER/Outpatie		Home 5 Residence	ce 6 Other (Specif	(y)
on (ding F h. After funer	Certification:	27. Manner of Déath 1 Natural 5 Pending (Moil 2) Accident investigation	nth, Day Year) 200. Times	Work? M 1 □ Yes 2 □ No	200. Describe now	illiary occurred	
VIS.	Atten r deat ector: by the	ifica	3 Suicide 6 Could not be 28e. Plac	e of Injury - At home, farm, s fing, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Rura	I Route Number,
ā	rs after el Direc	Cert	Balle	inig, etc. (<i>Specily</i>)		0.1, 0.7.0, 1.		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical Examiner: On the I		th occurred at the time, date and plac nvestigation, in my opinion, death occ			
	o the vithin 2 o tha o tha omple	Mec	29b. Signature and title of certifier	mor stated.	29c. License number	290	I. Date signed (Month,	Day, Year)
	Ö ← ≤ ←		> Slovandialti		D63174		09/06/0	5
	01		30. Name and address of person who completed cau	se of death (Item 23a) (Type		1		
	Sta	te		Registrar's Signature				
	Registr		SEP 0 9 2005	was to fig.	and it			

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UNKNOWN	
05-6013	

State of Maryland / Department of Health and Mental Hygiene 2055

1- State Amend Item 20b-c per fh G847 9-9-05 tas Registrar Reg. No. 29446 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 3, 2005 **Physician** reene A^{M} 0207 melvin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REISTERSTOWN BALTIMORE 11706 REISTERSTOWN ROAD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) 1 M 2□F mar Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at Yes 2□No Sattimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 112 81 death 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Black 1 ☐ Yes 2 → No Baltimore, Maryland 21215-0036 Specify: Specify. ð 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commercial Elementary/Secondary (0-12) College (1-4or 5+) movek moving Company House 144 NIA 18. Mother's Name (First, Middle, Maiden Surgame) 17. Father's Name (First, Middle, Last) and Mental h 1 and 2 should be lane Greene Greene malvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mother 3 Bryant Regalia Ct. Apt. E Owing, MILLS Heelth a md. 21117 Carolyn other 20c. Location - City or Town, State

/Dundalk, Md 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Pages 1
Department of H
Important: If ite
eny injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 3 ☐ Other (Specify) Tringty Cenetery -05 meral Service Licens 22. Name and Address of Facility 21. Signature 270 FredH KTON Pass P. march Funeral Home, Bacto, md. 2122 eyth disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat C use (Final disease of condition **Physician** GUISHER wound to NECK resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physiclan/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death USB USB 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4∏Pregnant at time of death 5 ☐ Other (specify) signed by the a o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of page 2 1 XYes 1XYes 2□No 2 No certificete of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE. 1∭XYes 2 ☐ No 2 ER/Outpatient 3 DOA 2 his After thi 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending s effer de. :50 AM 1 Yes 2 No investigation 9/3/05 SUBJECT SHET 2 Accident 3 ☐ Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Ryral Route Number, City or Town, State) outside Hospital or Kentempun, MTD within 24 hours e To the Funeral completely filled 29a. Certifier t Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifiq OCME SEPTEMBER 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thi

State Registrar

DHMH 17 Rev 1/2001

1A

32. Registrar's Signature

Carried Space

M. D 111 PENN STREET, BALTIMORE MARYLAND, 21201

Registrar

State

goldsmith

Hospital

2401 W. BEIVEDERE AVE.

Baltimork md 21215

30. Neme and address of person who ompleted cause of deeth (Item 23a) (Type, Print)

m.D.

Sinai

32. Registrer's Signature

Catherine Partyka

SEP 0 9 200

31. Dete filed (Month, Day, Year)

amend 5,20 per F.H. g849 11/10/05 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Matthew Joseph Goldsnuth 9000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore If Under 1 Year If Under HOSpita N/A **Funeral** 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 M 2□F Director Yrs. n/a Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at Baltimore Director 1 ☐ Yes 2 No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1936 Wa 11000 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: ō Baltimore, Maryland 21215-0036 Specity: White 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Matthew Jaseph Goldsnut VIDIO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau once. 1936 Walnut Jenniter Goldsmith / Mother undalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 9/23/05 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Prematurit disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) hysician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably page 2 should Be Compieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: Certification; To Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No NA after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C NIA Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) To the 29b. Signatur 29d. Date signed (Month, Day, Year) August 13, 2005 ss of person who completed cause of death (Item 23a) (Type, Print) 2401 Belvedere 31. Date filed (Month, Day 32. Registrar's Signature State 0 9 2005 Spark Registrar

			For Stata Registrar		State of M	arylan				lealth a Death	and Me		giene Rag. NJ.	005	29449
7.36	Physicia	an	1. Decedent's Name (F									2. Date of Dea Month	Day	Year	3. Time of Death
1	/Medic	al	Carol Ann 4a. Facility Name (If no		root and number			4h City	Town or	Location o		09	4c. Cou	ZOOS	626 P
-0	Examin	er	Franklin		. 1	Spi	tal		ose	E 4	2			citim	ore
	Funeral	. 8 .	5. Social Security Num	ber 6. Sex	7. A		ast birthday)		r 1 Year	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		219-38-444	1	M 2 X F	64	4 Yrs.					Feb. 27			yland
	and I		Usual Residence of De 10a. State 10	b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary I-f sh	tor	MID	Baltimore		Ros	sedale								1 ☐ Yes 2 No
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	ath w	rail	528 Patuxe			E	6 12		237	Vanania Osi	ain? (Sno		J.S.A.	Race - Amer	can Indian
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show deat Esambar must be codified at	Funeral	11. Marital Status 1 Never Married		 Was Deceden Armed Forces 1 ☐ Yes 2 € 	?				in, Mexican	n, Puerto P	cify Yes or No lican, etc.)		Black, White	etc.
936	al', or	þ	3 ☐ Widowed 4 [1 Yes 2 X If Yes, Give Year or Dates:			1 🗆 Yes	2X No	Specify:			Spe	ecity: Whi	te
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121	within then "	шрі	Elementary/Seconda	ary (0-12)	College (1-4or	5+)	Secr			,			Brass	/Alumi	ทาเพ
	than it	0	12th 17. Father's Name (Fin	st, Middle, Last)			Deci	ccar		18. Mothe	er's Name	(First, Middle,			Treati
/lan		To B	Arthur Kel	Baugh Abe	1					Mari	e Bai	rbara [annen:	felser	
Maryland	2 6 6 5		19a. Informant's Name						,			Route Number	-		p Code)
	of Health item 27		Keith Gre		ason	20b. P	lace of Dispe	osition (Na	me of	Avenu		osedale		21237 on - City or T	own, State
по				Cremation 3 □Re	moval from State		dens o				/12/2	2005	Roseda	ale, M	aryland
Baltimore,	permit. Page Department of Important: If eny Injury or once.		21. Signature of Fune		0+	=	2	2. Name a	nd Addre			ch/Rose	edale 1	Funera	
			23a. Part 1. Enter the	disease, or complic ailure. List only one	ations that cause	ed the deat									Approximate Interval Between
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	D H	iner	Sequentially list condi if any, leading to imm- cause. Enter Underly	ing 🚄	Due to (or a	s a con	uence of):								
<i>y</i>	sician and burial-transit	Examiner	Cause (Disease or infi that initiated events resulting in death) Las	c.	Due to (or a	s a conseq	uence of):	, sul	urc			-		-	
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687	ifficate g phy: as the	edic									12107.				
Вох	death certificate b attending physic I for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent p	regnant	ic. If yes, outcom	2 Feta	il death 3	⊒Ectopic		y			23d	Date of deligible Month	very Day Year
.O.	the at	/sici	in the past 12 m 1 Tyes 2 Th 9 Unknown	40	4□Pregnant 9□Unknown	at time of d	leath 5	Other (s	specify) _						
a	The law requires that the de ate has been signed by the bage 2 should be detached	/ Ph	Part II. Other significa	ant conditions conf	tributing to death	but not res	ulting in the t	underlying	cause giv	en in Part I	1.	23e. Did t	obacco use	contribute to	the cause of death?
Records,	quires t n signe	d by										10	Yes 2XN	lo 3 ☐ Pro	bably 4 Unknown
900	aw requir as been si 2 should I	Completed										24a. Was	DSV		opsy findings available ompletion of cause of
		Com										perfo 1 🗆 Yes	2 No	death?	2 □ No
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of	Phys this ral dia	. To	1 Yes 2 No) "	28a. Date of In	jury	ER/Outpatie		28c. Inju	4 🗆 NI		ne 5 🗆 Resi 28d. Describe			ify)
lon	Attending in death. ctor: After by the funer	ation	1 Natural 2 Accident	5 Pending investigation	(Month, E	lay Year)	Injury	М		rk?]Yes 2. [No				
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7	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai Ce	(Check only 2	Certifying Phys	er: On the basis	of examina									
	To the within 2.	Med	one) 29b. Signature and tit	le of certifier	and manner	Siated.		2	9c. Licen:	se number			29d. Date s	igned (Monti	, Day, Year)
	F 3 F 8		MB. XI	well.	X A	1			RE	5 00	000		9/	7/05	
	0,		30. Name and address	s of person who con	mpleted cause o	death (Iter	m 23a) (Type	Drint							D -
	1,		VDIR JOSE	ph Herch	elroa H	900	0 Fran	Klin :	Squa	re I	rive	Ball	more	- M	D 21237
1	St Regist	ate rar	31. Date filed (Month,	SEP 0 9 2	005 32. R	Gran's Signi	ature	goars.							

Greaver, Carol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 29450 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8, 3. Time of Death **Physician** September Elizabeth Cleora Gales 2005 5:20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sunrise Assisted Living Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex (Month, Day, Year)
December 12, 1926 Washington, D.C. **Funeral** Days Hours 1 □ M 2 🕅 F Yrs. 231-20-5846 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 N No Maryland Montgomery Germantown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23s or 19149 Grotto Lane 20874 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married 5 1 ☐ Yes 2 🕅 No Specify: White ģ 3 ☐ Widowed 4 💆 Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County filed within Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filled wir Department of Health and Mental Hygient Important: If item 27 ie marked other tha any injury or other traumatic event. Financial Assistant Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Raymond Heath Gertrude Cavan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19149 Grotto Lane, Germantown, Maryland 20874 Richard R. Gales/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State September 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 12, 2005 Rockville, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Funeral Service Licenses Ingelette Barris M01305 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stages Dementia Alzheimer's Type Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aneroxia Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Years Osteoporosis and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the 28 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🖾 No Day Year 5 Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoarthritis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🔯 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 September 8, 2005 4

Registrar

DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760,€

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Records,

Division of Vital

Begistrar's Signature

Tolf House Avenue, D-1, Frederick, Maryland 21701

30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 801

32

Allen Reilly, MD

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31. Date filed (Monga, Day

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Itimo	iit. Pages artment of ortant: If it injury or o		TADOTAL E DOMINICION O DITOTO VALUE	ETH HAME	EDROSH HAC 2. Name and Addres	GODOL 9/8,		ROSEDALE,		
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8760, 8	Medical Examine the private of the p	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Final that initiated events resulting in death) Last Due to (or as a constitution or constitution or cause or constitution or cause or constitution or cause on each line. Due to (or as a constitution or cause on each line. Due to (or as a constitution or cause on each line.	sequence of):					Interval Between Onset and Death	
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	12		30. Name and address of person who completed cause of death (I		Print)	No.	1/4 wes) nestyl	TO CONE	
	Sta Registr	- 1	31. Date filed (Month, Day, Year) SEP 0 9 2005		re e	KANDA	is con	- Angle	TND 4133	

	•	-	State of Maryland / Department of Health and Mental Hygien 2005 29452 Certificate of Death State of Maryland / Department of Health and Mental Hygien 2005 29452
	Physicia /Medic		Decedent's Name (First, Middle, Last) REGINA A. HARPER 2. Date of Death Month Day SEPTEMBER 6 2601 T TO M
)	Examin		A. Facility Name (If not institution, give street and number) NONTHWEST HOSPITAL 4b. City, Town, or Location of Death AWDALISTOWN SALTIMORE AUTHORIZE ACCOUNTY OF Death
	Funeral Director		Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 1
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	th with the 23s or 28s	Funeral Director	3902 HILTON Rd. APT 153 10f. Zip Code 21215 10g. Cilizen of What Country?
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aitimore,	nit. Pages 1 and artment of Healt ortant: If Itam 2: Injury or other 18.		10a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 6 Other (Specify)
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	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. AAVIMO, NHC, AATO. WP 21133
	St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature

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TO THE REAL PROPERTY.	7	23a. Part . Enter the disease, o comp shock, or heart failure. List only o	lications that caused the dea	th. Do not enter the m	ode ol dying, such as cardia	c or respiratory arrest		Approximate
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10,		MALIKA	ASPEM.	/ - 1	THIS I LEKN	DLV 11 -	1/1-1/-	421
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DHMH 17 Rev 1/2001

State Registrar

2005

4,

SEPTEMBER

SEORGE HARRIS

39. Registrar's Signature

SEP 0 9 2005

			For State Registrar	State of Marylar		artment of H		nd Mental H	ygiene Rog. No.	005	29455
	Dhysiai	an	1. Decedent's Name (First, Middle, Last)			,		2. Date of E Month	Day	Year	3. Time of Death
	Physici /Medio		Colleen Kelly Ho							2005	12:28 a.M
7	Examir	er	4a. Facility Name (If not institution, give s Franklin Square Ho			4b. City, Town, o		Death		ounty of Death timore	County
	5		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year	If Under 2		lirth	9. Birthp	place (State or Foreign
	Funeral Director			M 2√2 F 41		Months Days	Hours	Min. (Month, I	Day, Year) 5, 196	4 Tex	
	pu .		Usual Residence of Decedent 10a. State 10b. County	100 Ci	ty, Town or Lo	cation					0d. Inside City Limits
	shov	ក	Maryland Baltimo			timore					1 ☐ Yes 2 ☑ No
	28a-f	ect	10e. Street and Number		- 100.1	10f. Zip Code			10g. Citize	n of What Cour	ntry?
	3a or	Funeral Director	3908 Cutty Sark	Road			220		1	USA	
	deeth	nera	11, Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origi	in? (Specify Yes or f Puerto Rican, etc.)	No- 14	Race - Americ	
98	or its	F	1 Never Married 2 Marned	1 ☐ Yes 2 ☐ No	ŀ	1 □ Ye <i>s</i> 2√□No	Specify:	,			ite
21215-0036	72 hours after deeth with the Maryland natural; or items 23s or 28s-f show dical Examinal must be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:	16a Decer	dent's Usual Occup	ation		16h Kind	of Business/Inc	dustry
5	in 72 n "nai	Completed	(Specify only highest grade	completed)	(Give	kind of work done of NOT use retired	during most of)	of working	100.11	0. 200000	dasiry
212	d within giene. or then "	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Loan	Service	Agent		Ba	nking	
2	12 should be filed within hend Mental Hygiene. 7 is marked other then "Ireumatic event, Ira Mer	Bec	17. Father's Name (First, Middle, Last)	rion				's Name (First, Midd			
yla	Ment Ment Marked	2	James Francis O'B		T			ricia Rae			
Maryland	12 sh h end 7 is m treum		19a. Informant's Name/Relationship (Ty) Marvin C. Howell,					or Rural Route Num ad, Balti			
	1 and Heelth Iem 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of		Date		tion - City or To	
БĒ	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specity)	amoval from State		natory or other place Service (9-9-05	Tows	on, MD	
Baltimore,	그 튼튼증 .		21. Sign support Fundar Convice License		22	. Name and Addre	ss of Facility			•	
m	Depermine Company In C		23a. Part1. Enter the disease, or compli	1/	1	317 Cokes	sbury :	Home, P Road, Abi	nadon.	MD 21	009
6	Properties of the second of th	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	LERO" quence of): quence of):				_	ISEAR	Interval Between Onset and Death
8760,	ate be hysicie the buri	edical									
P.O. Box 68	death certific e attending p id for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 3[Ectopic pregnancy Other <i>(specify)</i>	,		230	d. Date of delive Month	ery Day Year
	8 20	۵	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.		tobacco use]Yes 2 □		ne cause of death?
of Vital Records,	The law require	Completed						24a. We	topsy formed?	prior to con death?	psy findings available mpletion of cause of
ital		0	25. Was case referred to medical				26. Place	of Death (Check only			
\$	Physiclen: this certific ral director,	To B	examiner? 1 XYes 2 □ No		ER/Outpatier	it 3 DOA Oth	er: 4 🗆 Nurs	sing Home 5□Re	sidence 6[∃Other (Specif	y)
	ding PI After ti funera		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor			e how injury o	ccurred	
isio	Attending r deeth.	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm etr		Yes 2 □ N		(Street and I	Number or Rura	al Route Number,
Division	after after Direct In by	Certification:	4 ☐ Homicide determined	building, etc. (Special	fy)	eet, factory, office			own, State)		
_	To the Mospital or Attending Ph within 24 hours after deeth. To the Funsrel Director: After th completely filled in by the funeral	edical C		islan: To the bast of my knor: On the basis of examina and manner stated.							
	within To the	Me	29b. Signature and title of certifier			29c. Licens				signed (Month,	
	01		· OueIZ_				CME		Septe	mber 5,	2005
	U/		30. Name and address of person who co	mpleted cause of death (Item			n Stre	et Balti	more,	Marylan	d 21201
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 9 20	32. Registrar's Sign	ature A	andi					

State of Maryland / Department of Health and Mental Hygien 2005 29456 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Joseph Francis Hain 2:45 а. м September 8, /Medical 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 5718 Cedella Avenue Baltimore N/A 8. Date of Birth (Month, Day, Yea March 31, 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Year) 1 X M 2 □ F Director 218-26-5241 73 Yrs ´1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural" ---- any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5718 Cedella Avenue 21206 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Liquidator 12 U.S. Custom Service 4 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Raphel Hain Mary Evangelist Purcell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret A. Hain 5718 Cedella Avenue / Wife Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9/12/2005 ^ 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Fund 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road Baltimore, MD Leonard J. Ruck, Inc. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician onsestive disease or condition resulting in death) months /Medical Due to (as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequent of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown has been pidemia 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Lesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After th 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours efter death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud. RMB206 15 5601 Loch Kayen Jouce Leno 2 Registrar's Signature 31. Date filed (Month, Day, Tan) State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend item 26 per doc 884/9-9-05 vt.

State of Maryland / Department of Health and Mental Hygiene 2005

29457 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day 1-17Am Betty Ihnat Lou /Medical September 2, 2005 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1100 Oak Avenue ESSEX
If Under 1 Year If Under 24 Hrs. Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F Yrs. Director 218-22-2759 76 8/17/1929 Maryland Usual Residence of Decedent with the Marylend 10a. State Hygiene. other than "natural", or heme 23a or 28e-f show rent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1100 Oak Avenue 21221 U. S. A. Pages 1 and 2 should be filad within 72 hours aftar death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ Yoo If Yes, Give Year or Dates: 11. Marital Status 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 2 3X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 27 is marked other ti r traumatic event, tr Dietary Consultant Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eventoe. Louis William Workmeister Thelma Catherine Jarrett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee Porter (Daughter) 351 Homberg Avenue Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 9/7 2005 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Paltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Fastern Avenue Essex, Maryland 21221 charl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical a MYOCARDIAL INFARCTION 5 HOURS Examiner Due to (or as a consequence of) Completed by Physician/Medical Examiner law requires that the death certificete be exacuted attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence of) Box 68760, Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown signed t END-STAGE DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Domer (Specify) Hospital: nours after death.

neral Director: Aftar this ca
filled in by the funeral dire ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ŏ 24 hours all 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune complately fil 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00062032 SEPTEMBER 2005 02 of person who completed cause of deeth (Item 23a) (Type, Print) 30. Name and address 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 31. Date filed (Month, Pay, Year) SEP 0 9 2005 32. Redistrar's Signature State Registrar

		•	For State Registrar	tate of Maryland	d / Depa <i>Cer</i>	rtment <i>tificate</i>	of Health a of Death	and Mental	Hygien		294	58
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Mary L. Irvine					2. Date	of Death th Da	ay Year	3. Time of D	
>	/Medic	al	4a. Facility Name (If not institution, give stre	et and number)		4b. City. T	own, or Location of	of Death	7 4	County of Death	10:30	PM
r	Examin		Coffman Nursing Home	et and number)			rstown	, Dou		ashingtor	ı	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. Ia 2∑F 94	ast birthday) Yrs.	If Under 1 Months	Year If Under Days Hours	Min. 8. Date Min. (Mon Novem	of Birth th, Day, Year ber 17,	9. Birthp Cour 1910 Virg	lace (State or itry) inia	Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City	Limits
	Mary P-f sho	tor	Maryland Montgomery	Ro	ckvill	Le					1 ☐ Yes 2	2 X No
	death with the Maryland ms 23e or 28e-f show	Funeral Director	10e. Street and Number			10f. Zip (_	itizen of What Cour ted State	-	
	s 23e	eral	11201 Schuylkill Roa	Was Decedent Ever in U.S	S. 13. V			gin? (Specify Yes		14. Race - Americ		
136	be filed within 72 hours after death with the Marylar Ital Hyglene. id other then "naturel", or liems 23e or 28e-f show other then "naturel", or liems 23e or 28e-f show event, the Marilest Examiner must be notified at	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	11	Yes, speci	fy Cuban, Mexicar 	n, Puerto Rican, e	tc.)	Black, White, Specify: Whi		
<u>ئ</u>	72 hou	eted	15. Decedent's Educat (Specify only highest grade of	ion ompleted)	(Give	kind of work	Occupation done during mos	t of working	16b. I	Kind of Business/In	dustry	
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	be filed valued by the Hygie ed other i	Be Co	17. Father's Name (First, Middle, Last)		Dazoo		18. Mothe	er's Name (First, M				
/lan		To B	David A. Good				Eliz	abeth Le	e Stri	.ngfellow		
Maryland	and s m		19a. Informant's Name/Relationship (<i>Type</i> , Daniel G. Irvine / S							or Town, State, Zip Marylan		2
če,	of Health item 27	l (20a. Method of Disposition	Court from State	lace of Disposemetery, cren	natory or otl	her place)	Date September		ocation - City or To		
Baltimore,	Pages Iment of tent: If it jury or o		1 X Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	rort			emetery	9, 2005	рге	ntwood, M	-	
Ball	permit. Pages. Department of the Importent: If ite any injury or of once.		21. Signature of Funeral-Service Licenses	<u>M01</u>	Roc 1433Roc	Name and Ckvill	le, Inc. Le, Mary	300 West Land 2085	Monts 0-280	phrey Fur comery Av	enue	ome/
, i	Physician		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition	tions that caused the death cause on each line.	n. Do not ente	er the mode	of dying, such as	cardiac or respira	tory arrest,	N	Approximate Interval Betwood Onset and De	een
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	44.	a tour	10100 0	2	6	Mur	UNI
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):	190	rivery.	descero			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):							
687	fficate g physics the	edical	d									
Вох	eath certifii attending p	ian/Me	23b. was decedent pregnant	If yes, outcome of pregna]Ectopic pre	egnancy			23d. Date of delive		ear
O. E	ne dea the at	Physici	in the past 12 mophs? 1 □ Yes 2 圖No 9 □ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (spe	ecity)				54,	
ď.	The law requires that the death certifi ite has been signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant conditions contri	buting to death but not resu	ulting in the	derlying ca	ugo givernin Part	23e	. Did tobacco	use contribute to the	ne cause of de	ath?
rds	w requires been sign should be		1 Commons	allen		geen	Micon	<u> </u>	1 ☐ Yes 2	2 €No 3 □ Prot	ably 4 Ur	nknown
Records,	law re	Completed	I ature of	isullali	ser .			24a	. Was an autopsy	24b. Were auto prior to co	psy findings a mpletion of cal	vailable use of
									performed? Yes 2 N	o death?	2□ No	
Vital	Physicien: r this certificated ral director,	o Be	25. Was case referred to modical examiner? 1 Yes 2 Hos	pital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	it 3□ DO	Other	e of Death (Check		6 ☐Other (Specif	v)	
ס ר	를 들 들	H	27. Mannel Ceath	28a. Date of Injury (Month, Day Year)	28b. Time of		Bc. Injury at Work?		scribe how inj		,,	
sior	Attending or death. ector: After by the fune	catlo	1			М	1 Yes 2		otion (Canada	and Alicentes and Occur	d Davida Mumb	-
Division	or Attendates after deat	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory,	, office	281. Loca City	or Town, Sta	ind Number or Rura te)	u Houte Numb	er,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical C		ian: To the best of my knor: On the basis of examinal and manner stated.								
	within To the	Me	29b. Signature and title of certifier	^		29c.	License number	7	29d. D	ate signed (Month,	Day, Year)	
,	*		Hower Char	(mD			D 366.	> ~	uy	1 6,00	101	
	10		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print) Say	muel Cha	n, M.D. USTIWN,	MD	31740		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 29459 For Steta Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 10:58 PM peptember 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Hospital Year If Under 24 Hrs. Harbor nter 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 5 212-42-5618 1**X** M 2□ F Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County If item 27 is marked other then "natural", or items 23s or 28s-1 show or other treumetic event, the Medical Example, an inust the confilled at 1 Yes 2 No Directo Marylana 10e. Street and Number moce 10g. Citizen of What Country? 10f. Zip Code 21216 the. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Ā Specify 3 ☐ Widowed 4 👿 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -purpose mou d 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Informant's Name/Relationship (Type, Print) (mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VId. 21216 alto. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Town, State 20c. Location -20a. Method of Disposition permit. Pages Department of Importent: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GreenMount injury (^¹ 4 □ Donation remater 22. Name and Address of Facility
Joseph L. Russ
2222 W. North 21. Signature of Funeral Service Licensee any ir Home, P.A Balto. Ave. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part Enter the dishock, or heart failu Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death **Physician** IV YEOU /Medical Due to (or as a consequence of) **Examiner** tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and s the burial-trans (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 Probably 4 □Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? this certificate 1 ☐ Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 100 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Matural 5 Pending 1 Tes investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 3001 Baltimore Street AMARER Hanover 32. Registrar's Signature 31. Date filed (Month, Day, Year.

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 29460 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:22 PM M. 09 05 Alice 2005 bransen /Medical 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death 4c. County of Death rive street and number) Examiner University of Maryland Medical N/A 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Monthy Day, **Funeral** 1 □ M 2 F Days Hours 265-12-4337 0H 8/2 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23a or 28e-f ehow the Medical Examiner must be notified at Bpwling Green 1 Yes 2 No Wood Be Completed by Funeral Director Ohio 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43402 USA 915 Carol Road filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 12 Registered Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hent: If Item 27 is marked oft jury or other traumatic even Charles W. Robertson Nellie Mae Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Carol Road, Bowling Green, OH 43402 James D. Jorgensen (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. Bowling Green, Ohio 4 ☐ Donation 5 ☐ Other (Specify) Union Hill Cemetery 21. Signature of Funeral Service Liceny 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Pant. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 hours brain /Medical consequence of): Examiner Struck Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of CENTERATION REPROVED BY MEDICAL ENAMINES Examiner physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 19 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner?
Yes 2□ No 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 1 Inpatient 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: PEDESTRIAN HIT BY VEHICLE Natural 5 Pending investigation 11:30 AM 1 🗌 Yes death. Accident after death | Director: / d in by the f 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 517 NEWBERRY CT, DOPPA, HD STREET within 24 hours a To the Funerel C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7 completed cause of death (Item 23a) (Type, Print) University of Hayland Medical Center

Registrar DHMH 17 Rev 1/2001

State

Marie 31. Date filed (Month, Day, Year)

SEP 0 9 2005

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19b per fin 2847 9-05 vt
State of Maryland / Department of Health and Mental Hygiene 0 5

29461 1 - For State Registrer Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 1:23 JOHNSON SEPT 3005 AAL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A CITY BALTIMORE HOPKINS HOSPITAL THE JOHNS If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax **Funeral** Months 1**X**M 2□ F O Yrs. 215 • 42 • 6510 Usual Residence of Decedent MS 02.21. Director the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore Catonsville 1 ☐ Yes 2 No Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1523 King William Drive USA or Items 23g permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any jinjury or other traumatic event, It a Marical Examination 2008. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ es 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Yes. Give þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) eyears sustems Malust 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frankie Winght Manuel Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow Catonsvi) 11e 19a. Informant's Name/Relationship (Type, Print) 1523 William Drive Md. 21228 Francine Junson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 Removal from State 09.12.05 Dwings Mills Garnson Forest • 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
6151 Baitimore National Pike Baito. MD 21229 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PULMONARY

Due to (or as a consequence of): Immediate Cause (Final Physician HEMORRHAGE Hours disease or condition resulting in death) /Medical Examiner FAILURE HEART 3 WEEKS Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consuguence of): Examiner certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Wunknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No his 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Hospital or Attending 1. Natural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I Medicel Exeminer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contriber M.D RES-100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BALTIMORE, MO 3 600 N WOLFE ST. ERIC 22. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2005 Registrar

05-6034 B.K.S DAVID G. JACKSON

Please 1

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Maryland	should be nd Menta i marked umatic ev	5	George C. 19a. Informant's Name/Relation)	19	b. Mailin	a Address	(Street	and Numb		eraldi Route Numb					
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			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications t	hat cause on each	d the death Do						respiratory a				Approxima Interval Be	tween
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68760,	ertificate be executed ding physician and se as the burial-transit	Medical		d													- 52
~	anit ding		IF FEMALE: 23b. Was decedent pregnant	23c. If yes	s, outcom	e of pregnancy								23d. Da	te of delive	erv	
Bo	ettend for us	Physician	in the past 12 months?			2 ☐ Fetal deat at time of death		Ectopic pr Other (sp							nth		Year
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	± 29 ag	by P	Part II. Other significant condi	tions contributing	to death	but not resulting	in the ur	nderlying c	ause give	en in Part	I.	23e. Did	tobacco	use cont	ribute to t	he cause of	death?
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	. ~		30. Name and address of person	n who completed	Cause of	death (Item 325)											
	10		MAWADATA	A V M	ال قوليد	111	PEN	N ST		, BAL	TIMOR	E,MARY	LAN	D 212	201		
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State of Maryland / Department of Health and Mental Hygiene 2005 29463 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frank Bacchus Johnson, Sr., M.D. Sept. 2005 /Medical 2148 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1⋤M 2□ F Months 326-28-8468 Director 86 Wash. . D.C. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at 1 TYes 2 □ No Director MD Montgomery Potomac 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8504 White Post Court *natural', or items 23a 20854 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1945 1 ☐ Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Pathologist 5+ Medical 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt.
Department of Health and Mental Hy
Importent: If Item 27 Is marked oth
any injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be James Lee Johnson, Sr. Gertrude Bacchus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8504 White Post Court, Potomac, MD Frank B. Johnson, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 9/6/05 Beltsville, MD Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00382 21. Signature of Funeral Service Licensee

Moo382

22. Name and Address of Facility
Rapp Funeral and Cremation S

Silver Spring, MD 20910

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Rapp Funeral and Cremation Services 933 Gist Ave Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine erebro that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant al time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, essencion 1 XYes 2 No 3 Probably 4 Unknown Completed nentia 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a Wasan this certificate has von sclentre ceeve 1 ☐ Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 XNo of 27. Manner of Death 28a D te of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending (Month, Day Year) Division Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hour.
*he Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check ont one) 29b. Signature 30. Natione and add rson who completed cause of death (Item 23a) (Type, Print) RIVN. 6 320 Derwiren 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

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			1 - For State Registrar		artment of Health and Nartificate of Death		ene 2005	29464
	Dhysis		Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
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			Montgomery General F 5. Social Security Number 6. Sex		01ney		Montgome	
B	Funeral Director		578-01-6015 ^{1∑™}	7. Age (In yrs. last birthday) 2 F 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) March 1	9. Birthp Court 5, 1921 N	place (State or Foreign ntry) Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	10d. Inside City Limits
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	r 28a	rec	10e. Street and Number	DIIVEI	10f. Zip Code	100	g. Citizen of What Cour	Λ
	th with	ai D	15301 Pine Orchard D	rive	20906		United Sta	
	ams	ner	11. Marital Status	Vas Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	can Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event. The Mardical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1	TYPS 2 No 10/6	1 Yes 2XXio Specify:	rican, etc.)	Black, White, Specify: W	_{etc.} hite
2-0	72 ho natur	eted	15. Decedent's Educatio (Specify only highest grade cor	n 16a. Dece	dent's Usual Occupation	16	6b. Kind of Business/Ind	dustry
2	vithin ne. han "	mpie		Ollege (1-40r5+)	kind of work done during most of work DO NOT use retired)	irig	photo	
S	iled v Hygie thar t	Co	17. Father's Name (First, Middle, Last)	2	tographer	VET - 1 45 1 11 1 1 1		
Maryland	d be a	o Be	Ernest Jennings			e (First, Middle, Ma		
2	shoul nd Me mark mati	To	19a. Informant's Name/Relationship (Type, F	Print) 19b. Mailir	Anna] ng Address (Street and Number or Rura	Estella B	rown Jenni	ngs
Š	nd 2 alth a 27 is r trau		Shelley Jennings/Dau		pring Park Avel,			
J.e	itam itam otha		20a. Method of Disposition	20b. Place of Dispo			c. Location - City or To	
altimore,	Page		1 ☐ Burial 2 X ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	rai iroiii otato	ke Crematory 9/7	/05 B	eltsville,	MD
Balt	permit. Departr Imports any inj		21. Signature of Funeral Parvice Licensee	M00382 R	Name and Address of Facility app Funeral and Cr	emation	Services	
ľ	6,*		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do not enti-	33 Gist Ave Silver er the mode of dying, such as cardiac c	Spring or respiratory arrest	MD 20910	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition					Onset and Death
П	/Medical Examiner		resulting in death)	Congestive Hea				1 week
		-	Sequentially list conditions, b	Severe Coronary Due to (or as a consequence of):	Artery Disease	<u> </u>		years
	ted nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			!	
,	icate be executed physician and s the burial-transit	Examiner	that initiated events c c	Due to (or as a consequence of):				
8/60,	physicia physicia the bur	dicai	d					
٥	ng ph as th	Jedi	IF FEMALE:					
X Q	death certifi e attending p id for use as	Physician/Me	23h Was decedent progrant 23c. If	yes, outcome of pregnancy □Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of deliver	,
	0 0 0	ysic	1 Yes 2 No	☐ Pregnant at time of death 5☐ Unknown	Other (specify)		Month	Day Year
ı	requiras that the		Part II. Other significant conditions contribu	ting to death but not resulting in the ur	iderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
cords,	quiras n sign ald be	d by					2 □No 3 □ Proba	
ဝင္ပ	> 0 70	Completed				24a. Was an	24b. Were autop	psy findings available
r	0 - 0	mo				autopsy performed	prior to com death?	npletion of cause of
Vital	ystcian: This certificate director, pag	Bec	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	INO I LUTES :	2LI NO
_	his I di	2	1 ☐ Yes 2 🛣 No Hospit	1 Minpatient 2 LEH/Outpatient	Other: 4 Nursing Hon	ne 5 Residenc	e 6 Other (Specify,)
	ttanding Phys death. tor: After this r the funeral dir	on:	1 Natural 5 Pending	a. Date of Injury 28b. Time of (Month, Day Year) Injury	Work?	8d. Describe how	injury occurred	
ISION	death ctor: / the i	icat	Accident investigation 3 Suicide 6 Could not be	o Place of Injury. At home form at a	M 1 Yes 2 No	104 Landing (Ch.)		
2	al or A after I Dirac d in by	Certificati	4 Homicide determined 20	 Place of Injury - At home, farm, streed building, etc. (Specify) 	eet, factory, office	City or Town, S	t and Number or Rural itate)	Route Number,
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	dicai	(Officer off) Z in medical examiner; (In the basis of examination and/or inv	occurred at the time, date and place, a estigation, in my opinion, death occurre	nd due to the caus	e(s) and manner as sta and place, and due to	ited. the cause(s)
	ro the vithin or the omple	Mec	29b. Signature and title of certifier	nd manner stated.	29c. License number		Date signed (Month, D	
	> 1- 0		4	7 m	D43202		ptember 6,	*
v	IXI	1	30. Name and address of person who complete	d cause of death (Item 23a) (Type, F	Print)			2003
1	171		C. Ozanne-Blankfor		ure World Blvd, S	ilver Spr	ing, MD 2	0906
	Star Registra	_	31. Date filed (Month, Day, Year) SEP 0 9 2005	32. Registrar's Signature	nealles			

			1 - State State Registrar	of Maryland / [Department of I Certificate of			ne no2005	29465
			Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
ı	Physicia /Medic		William LeRoy Jen	nings			Septem		57:30pm
	Examin		4a. Facility Name (If not institution, give street and r	umber)	4b. City, Town,	or Location of Death		4c. County of Death	
T			Moriner Health of		Del	Air		Hart	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	rthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye NOV • 27,	1924 Penn	lace (State or Foreign sylvania
	Director		Usual Residence of Decedent	80			NOV. 21,	1924 Feili	syrvania
	/land		10a. State 10b. County	10c. City, Tow	vn or Location			1	0d. Inside City Limits
	Many 9-1 sh	to	Maryland Harford	Bel	Air				1 ☐ Yes 2 X No
	th the	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coun	ntry?
	23a		951-D Redfield Road		210			USA	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinat must be multified at	by Funeral	Armed	ecedent Ever in U.S. Forces? S 2 No Sive	13. Was Decedent of If Yes, specify Cub	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
Maryland 21215-0036	hour fural	ed b	15. Decedent's Education		a. Decedent's Usual Occu	pation	166	o. Kind of Business/Inc	
L.	in 72 n "ne Nedis	Completed	(Specify only highest grade completed		(Give kind of work done life. DO NOT use retire	during most of work	ing		
212	d with giene er than	E O	12		echanical En	gineer	U	.S. Govern	ment
פ	e file al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, Mai	den Sumame)	
/lai	wild b Ments arked	2	William Wesley Jen	nings			M. Edward		
lan)	2 sho and I s me		19a. Informant's Name/Relationship (Type, Print)		b. Mailing Address (Stree 306 N. Pine				
	and lealth m 27		David Jennings / Son		of Disposition (Name of			c. Location - City or To	
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State cemete	ery, crematory or other pla	ace)		owson, Mar	
Ħ	it. Pa rtmen rtant: njury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sirvice Licensee	HILL	cop Service			JWSUII, MAI	yrand
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other tra once.		Mille a Gin	11-1	McComas F	uneral Honesbury Road	me, P.A. d. Abinado	on, Maryla	nd 21009
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause	couped the death. Do					Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	NONIC (to (or as a consequence	Obstruct	ive Pa	lmonar	y Diceae	Onset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence	of):				
8760, (cate be executed physician and the burial-transit	I Examiner	that inflated events c	to (or as a consequence	of):				
87	cate t	dical	d						
.O. Box 6	The law requires that the death certificate be executed site has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant	outcome of pregnancy e birth 2 Fetal death gnant at time of death known	h 3 Ectopic pregnand 5 Other (specify)	су		23d. Date of delive Month	ery Day Year
Δ.	that t ed by detac	/ Ph	Part II. Other significant conditions contributing to	death but not resulting	in the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute to the	ne eause of death?
dS,	w requires t been signe should be	d by	tailure to	thrive	2		1 ☐ Yes	2 No 3 Prob	oably 4 Unknown
Vital Records,	w rec s beel	Completed	7000	,			24a. Was an	24b. Were auto	psy findings available mpletion of cause of
Re	Physician: The law r this certificete has sral director, page 2 a	шо					autopsy performed 1 Yes 2	death?	2 No
ta	an: 'tifice	a)	25. Was case referred to medical			26. Place of Deat	h (Check only one)		
	Physician: this certific ral director,	To B		☐ Inpatient 2 ☐ ER/O	outpatient 3 DOA			e 6 □Other (Specif	y)
0 _	ding Pt		27. Manner of Death 14 Natural 5 ☐ Pending (M		Time of 28c. Injury We		28d. Describe how	injury occurred	
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation			Yes 2 □ No	29f Location /Stree	et and Number or Rura	al Poute Number
Division of	or At after d Direct in by	Certification:	dotermined 206. Fig	ilding, etc. (Specify)	farm, street, factory, office	•	City or Town, S		11 / 10010 / 10111001,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Co	29a. Certifiler (Check only one) 29a. Certifiler (Check only one) 2 ☐ Medical Examiner: On the and m	the best of my knowledg b basis of examination ar anner stated.	ge, death occurred at the and/or investigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner as s and place, and due to	tated. o the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	1010	29c. Licer	nse number	29d.	Date signed (Month,	Day, Year)
	1 \		(I amy	11/4/	-n)	21938	5 Pe	pkmber	4,2005
	8.41		30. Name and address of person who completed co	ruse of death (Item 23a)	(Type, Print)	8 Lai	u Stva	et Aber	deen
	Sta	ate		Registrar's Signature	. 18	170	ryland	1 2	UO !
	Regist		SEP 0 9 2005	Been Si	house				
			69		e /				

DHMH 17 Rev 1/2001

William Jennings

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 29466 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 5, 2005 Joyce Allene Jenkins 9:09 A. M /Medical 4a. Fecility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Y)
July 18, 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Year) 1933 Maryland 1 □ M 2 🕅 F 577-46-6207 72 Director Yrs July Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 7 is marked othar then "natural", or itams 23e or 28a-f show traumatic evant, it a Madical Examiner is ust be nutified at 10d Inside City Limits Directo 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 death Funeral 7208 Exeter Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after on and Mental Hygiene. Is markad othar then "natural", or Itar Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 <u>></u> 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
National Institutes (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) of Health Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jasper Loring Jenkins Vallie L. Beahm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 Is 1 Suzanne M. Snedegar/Attorney 4824 Edgemoor Lane, Bethesda, Maryland 20814 20b. Place of Disposition (Name of Montgomery crematory or other place) 20a. Method of Disposition September 9. 20c. Location - City or Town, State ò 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. ¹ 4 □ Donation

² 5 □ Other (Specify) Crematorium, Inc. 2005 Bethesda, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Robert A. Pum Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-3501 Pumphrey Funeral Home/ - 755/ Wisconsin Avenue M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Septic Shock /Medical Due to (or as a consequence of): Examiner Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Physiclan/Medical as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Ā Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Acute Renal Failure 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Acute Respiratory Failure 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy rmed? 2K No Amyctophic Lacteral Solerosis 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28h. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1000 Mond -P. 17656 M.D. 9105105 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOODWARD # STO Chem CNURR WO SORIS TIPAPORN W.D WISCONSIN NV 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar SEP 0 9 2005

Jenkins

		•	For State Registrar	State o	of Marylar	•	artment of F		ind Me		jiene eg. No 20	05	291	+67
	٥		Decedent's Name (First, Middle, Last) 2. Date of Death Month							th Day	Year	3. Time of	Death	
	Physicia /Medid			Peggy	Eleanor	Kaise	r				per 6, 2		6:03	P M
4	Examin		4a. Facility Name (If not institution, give	street and nu	ımber)		4b. City, Town, o	r Location of	f Death		4c. County	of Death		
	1		Washington Adven					a Park			Mont		-4	
e, maryland z i z i 5-0036	Funeral	Director	5. Social Security Number 6. S	ex □M 2【X】F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours 1	Min.	8. Date of Birth (Month, Day July 21	Year)	Cour		r Foreign
	Director		219-28-4870 Usual Residence of Decedent		74	115.		1		July 21	, 1931	Mar	yland	
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	0d. Inside Ci	ty Limits
	Manyl feho		MD Prince	George!	S	Beltsv	ille						1XXYes	2 🗌 No
	28a		10e. Street and Number				10f, Zip Code			1	Og. Citizen of W	hat Cour	itry?	
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	ms 2	Funerai	11. Marital Status		edent Ever in U	.S. 13.	Was Decedent of H		in? (Spec	cify Yes or No-	14. Race	- Americ	an Indian,	
	after or Ite	∄	1 Never Married 2 Married		217] No		1 ☐ Yes 2X No	Specify:	, rueno n	ticari, etc./	Specify	white.	ite	
	d within 72 hours after death with the Marylan piene. Ir than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	dby	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates:		103 201110							
	72 h natu	ete	15. Decedent's Ed (Specify only highest gra	lucation <i>de completed)</i>		(Give	dent's Usual Occup kind of work done	during most	of workin	g	16b. Kind of Bu	siness/In	dustry	
	within ne.	To Be Completed	Elementary/Secondary (0-12)		1-4or 5+)		DO NOT use retire dress	a)			Industr	ial	Lowel	Co
	Hygie thert		12th 17. Father's Name (First, Middle, Last)	Ø		Daum	aress	18. Mother	r's Name	(First, Middle, I	Maiden Sumam		TOWET	CO.
	2 should be fited and Mental Hygie and Mental Hygie Is marked other sumatic event, It			known							Vincent	,		
	should ind Men s marke umatic		19a. Informant's Name/Relationship (19b. Mailie	ng Address (Street	and Number				State, Zip	Code)	
	and 2 s saith ar n 27 is ser trau		David Kaiser/Son	,, ,			6 Shenand						21784	
	Heg Heg tem othe		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	201	Da	ate	20c. Location -	City or To	wn, State	
	Pages nent of I ant: if its ary or o		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specification)		State		oln Cemet		/13/	2005	Brentwo	od,	MD	
	2 2 2 2		21. Signature of Funeral Service Vicer				2. Name and Addre				Funera	l Ho	me, P.	Α.
ď	Departimon Important		M00160 313 Talbott Avenue, Laurel, MD 20707											
	T .		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): CARDIA CTEMPUNADE Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
*	Physician													
	/Medical		resulting in death) Due to (or as a consequence of): TNFO O-TIOA/											
	Examiner		Sequentially list conditions by CARDIACTEMPONADE											
	יי פ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):						,					
	ecute and trans	cam										_		
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OX O	Jeath certific attending p	/Me	IF FEMALE:	23c. If yes, ou	tcome of pregn	ancy		· ·			23d Date	of delive	in.	
9	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown							23d. Date of delivery Month Day Year			/ear	
j.	the d y the iched	Physician/M												
Σ.	requires that the death certificate een signed by the attending physinould be detached for use as the	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							bacco use contribute to the cause of death?				
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		Completed	, (,)							24a. Was a		ere auto	psy findings	available
T E	sician: The law certificate has t lirector, page 2 s									autops perform	med? d	eath?	inpletion of ca	1029 01
or vita	rtifica tor, p	0	25. Was case referred to medical					26. Place	of Death	(Check only on				
	> 0, 0	To B	examiner? 1 Yes 2 No	Hospital: 1 🗹	Inpatient 2	ER/Outpatier	at 3□ DOA Oth	er: 4 🗆 Nur	sing Hom	e 5 Reside	ence 6 Othe	r (Specify	1)	
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28b. Time of Injury	of 28c, Injury at Work? 28d. Describe how injury occurred									
	endin eath. or: A he fu	satic	2 Accident investigation		M 1 🗆	Yes 2□N	10							
Ĕ	r Att	Medical Certificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)						21	28f. Location (Street and Number or Rural Route Number, City or Town, State)				ber.
2	urs af urs af grail D													
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.)		
	o the ithin o the omple		29b. Signature and title of certifier. 29c. License number						2	9d. Date signed	Date signed (Month, Day, Year)			
	⊢ 3 ⊢ ŏ						36192 CARPOLLAVESUITE			C				225
	λ		30. Name and address of person who	completed cau	se of death (Iter	п 23a) (Tvpe.	Print)	1	-	3	_ /)	-, _	000
	~		ANEES ALLSA	N,M	.Δ	76100	ARROLLI	AVES	UTTE	= 410,TA	AKOMA/A	RK,1	MD20	1912
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7.	Registr	ar	5 5	1000	Rague -	K	6.10							

ORIGINAL

			For State Registrar	State of Ma	arylan		artment of F rtificate of I		d Mental Hy	giene Reg. No. 4	2005	29468	
	Physici /Medio		1. Decedent's Name (First, Middle, Las Daisy Virginia I	kelly					2. Date of Do Month	Day	Year \$ 2005	3. Time of Death	
	Examir Funeral	ner	4a. Facility Name (If not institution, give Franklin Square 5. Social Security Number 6. S	HOSpital		last birthday) Yrs.	4b. City, Town, or hose da If Under 1 Year Months Days	Le If Under 24 H	eath	4c. C	County of Death A / 17 / 17 / 19. Birthp Court	place (State or Foreign	
Baltimore, Maryla	Director		Usual Residence of Decedent		8!				Aug. 15	, 1920	Virg	LN1a Od. Inside City Limits	
	Maryla -f show lled at	tor	10a. State 10b. County Maryland Baltimor	æ		y, Town or Lo SEX	cation					1 ☐ Yes 2XXNo	
	vith the	Director	10e. Street and Number				10f. Zip Code	00		10g. Citizen of What Country? U.S.A.			
	I within 72 hours after death with the Marylan itene. r than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	Funerai	1602 Aldeney Avenu	12. Was Decedent I Armed Forces? 1 □Yes 201		S. 13.	Was Decedent of Hif Yes, specify Cuba		(Specify Yes or No uerto Rican, etc.)		4. Race - Americ Black, White,		
	hours at tural', or al Eyem	by	3∕25Widowed 4 □ Divorced 15. Decedent's Ed	If Yes, Give Year or Dates:		3	1 ☐ Yes XXNo dent's Usual Occup	Specify:			Specify: What of Business/Inc	nite	
	within 72 ene. than "na ha Medic	Completed	(Specify only highest gra		i+)	(Give	kind of work done on DO NOT use retired	during most of	working		n Home		
	d tal	o Be C	17. Father's Name (First, Middle, Last) Lindsey C. Wilson						Name (First, Middle Bell Lam)		Gumame)		
	d 2 should th and Men 7 la marke traumatic	Ĕ	19a. Informant's Name/Relationship (and Number or	Rural Route Numb	er, City or			
	teal m2		Merry Jane Wasmer 20a Method of Disposition	(Daughter	20b, P	lace of Dispo	sition (Name of	Ţ	Baltimo:		aryLand ation - City or To		
	permit Page Department of Important: If Impo		A⊠ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify			lly Hi		ard Aug	g.12,2005				
			21. Signatura of Far Jar Service Licensee 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 old Eastern Avenue, Essex, Maryland 21221										
			23a. Part1. Ever the disease, or com shock, if heart failure. List only	plications that caused one cause on each lin	the death							Approximate Interval Between Onset and Death	
			Immediat - Cause (Final disease or sendition resulting in death)	a. Kuptu			minal i	aortic	aneur	15 m		6 hours	
		ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
		Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):									
09/89	ficate be physicists the bu	edicai		d									
or Vital H	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	decedent pregnant past 12 months? 23c. If yes, outcome of pregnancy 1						23	23d. Date of delivery Month Day Year		
	w requires that in been signed by should be detailed.		Part II. Other significant conditions of	conditions contributing to death but not resulting in the underlying caus						tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Frobably 4 □ Unknown			
	ng Pnysician: The iffer this certificate h uneral director, page	Completed							24a. Was auto perfi 1 \(\triangle Yes		24b. Were auto prior to con death? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of 212 No	
		o Be	25. Was case referred to medical examiner? 1 ▼ Yes 2 □ No	Hospital:	nt 2 3	ER/Outpatier	nt 3 DOA Oth	OF:	Death (Check only g Home 5 Res		□Other (Specif	iv)	
		1	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28b. Time of Injury	f 28c. Injur Wor	y at	28d. Describe			,,			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, facto building, etc. (Specify)					office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	f examina	wledge, death tion and/or in	h occurred at the tir vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the courred at the time,	cause(s) a date and p	nd manner as st place, and due to	tated. o the cause(s)	
	To th To th comp	Me	29b. Signature and will of certifier full	ew .			29c. Licens				signed (Month,		
			30. Name and address of person who	completed cause of d	eath (Item	1 23a) (Tvoe	Print)	138946	ve Ba/	Septe	mber 8	2005	
	N		Dr. Christophe	ryou 9	3000 1	Frank	LIN Sque	are Dri	ve Ball	hmoi	-e,Md2	2/237	
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 9 2	32. Riegistra	ars Signa	S A	beels						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** MARK ANDREW KESSELAK SEPTEMBER 2, 2005 6:40 P. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE LAUREL LAUREL REGIONAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 47 JULY 5,1958 PENNSYLVANIA Director 193-52-7731 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, it e Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director LAUREL HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9620 M. HOMESTEAD COURT USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1

Never Married 2

Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CONDUCTOR **CARGO** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANDREW KESSELAK, JR MARY RADASKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16149 WEST LAPALAMA, SUNPRISE, ARIZONA 85374 MARY KESSELAK / MOTHER other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ö permit. Pages Depertment of Importent; If i any injury or o 1 Burial 2 ☐ Cremation 3 BRemoval from State GRAND VIEW CEMETERY 9/10/2005 JOHNSTOWN, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 MONTH **Physician** ESOPHAGEAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit The law requires that the death certificate be executed Due to (or as a consequence of): use as the burial Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 🗆 No Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perfo 20 certificate 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 2 ER/Outpatient 3 DOA 1 TYes Inpatient 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 2 No 1 TYes after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funeral 6 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAVRER M 2070 MART 1 Ri NO SABELL 327 Registrar's Signature 31. Date filed (Month, Day, 9 2005 State Registrar

DHMH 17 Rev 1/2001

030		1 - For State Registrar	State of M	aryland			nt of He te of L		nd Menta		ne 20	05	2947
Physic /Medi		1. Decedent's Name (First, Middle, Last Lily M. Kibildis							Mor			'ear 2005	3. Time of Death 2:19 P
Exami		4a. Facility Name (If not institution, give 3913 Kincaid Terra	ice			Kei	nsing	Location of 0		(5)	4c. County of	ome	
Funeral Director		5. Social Security Number 6. Se 202–30–5899	7. A	ge (In yrs. Ia	Yrs.	Months	r 1 Year Days		Min. (Mor	of Birth oth, Day, Y	ear)	Coun	lace (State or Foreig stry) sylvania
Maryland	tor	10a. State 10b. County Maryland Montgomer	у		Town or Lo							10	0d. Inside City Limit 1 ☐ Yes 2 🕅 N
th with the 23a or 28a	Funeral Director	10e. Street and Number 3913 Kincaid Terra	ıce				Code 895				Citizen of Wh		•
be filed within 72 hours after death with the Maryland ital Hygiene did the file of the fi	þ	11. Maritat Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	? No		Was Dece f Yes, spe I □ Yes		spanic Origin n, Mexican, F Specify:	n? (Specify Yes Puerto Rican, e	or No- tc.)	14. Race - Black, Specify:	Americ White,	etc.
Definition of the proof of the	Completed	15. Decedent's Edd (Specify only highest grad Elementary/Secondary (0-12)			16a. Deced (Give life. I	kind of w DO NOT L	ork done d ise retired)	uring most o	f working		b. Kind of Busi Hospita		dustry
should be filed and Mental Hygi marked other urnatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Joseph A. Kibildis			110825			18. Mother's	Name (First, and M. W	Middle, Ma	iden Sumame)		
s 1 and 2 should t f Heelth and Ment item 27 le market other treumatic		19a. Informant's Name/Relationship (7) Anna R. Kibildis/S			78 Kr	ox S	treet	, Han	or Rural Route over To	wnshi	p, PA.	187	06
permit. Pages 1 and 2 Depertment of Heelth a Important: If item 27 it eny injury or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Mon	ace of Dispo metery, cren Egomer emator	natory or	other place Inc.	7	ptember	Ве	thesda	. Ma	rvland
permit Deper Impor eny in		21. Signature of Fun all Servoy cens 23a. Part1. Enter the disease, or comp	MO	01353			_					Av	eral Home enue
Physician /Medical Examine published physician and physician and physician and physician street physician street physician phy	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a: Due to (or a: Due to (or a:	s a conseque	ence of):) (· · · · · · · · · · · · · · · · · ·	usn	703	01-31		
ne death certifi the ettending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 S No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3□	Ectopic p	oregnancy pecify)				23d. Date Month		Pry Day Year
requires thet the been signed by should be detact	ρ	Part II. Other significant conditions co	ntributing to death	but not resu	lting in the u	nderlying	cause give	n in Part I.	236				ne cause of death? ably 4 ⊠Unknow
(0)	Completed									. Was an autopsy performe Yes 25	d? prid	or to cor ath?	psy findings availab npletion of cause of 2 No
Physician: 1 this certifical ral director, p	o Be	25. Was case referred to medical exeminer?	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatien	t 3 D	OA Othe		f Death (Check		e 6 Nother	/Specifi	at scene
Attending Physic death.	 -	27. Manner of Death 1 ♥ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inj (Month, D	urv	28b. Time of Injury		28c. Injury Work	at	28d. De		injury occurred		,, 40 500110
To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the tu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of In building, e	njury - At hor tc. (Specify)	me, farm, str	eet, facto	ry, office			ation (Stree or Town, S		or Rura	i Route Number,
Hospitel 24 hours a Funeral etely filled	edical	(Check only one) 1 Gartifying Phy 2 Medical Exami		of examinati									
To the within 2 To the comple	Me	29b. Signature and title of certifier	e Yhu	e h	w	29	c. License	number O.C.M.	Е.		Date signed (
1241		30. Name and address of person who c	ompteted cause of				n Stı	eet,	Baltimo	re, M	arylano	1 21	201
St. Regist	ate rar	31. Date filed (Month, Day, Year)		trar's Signat	ure		/						

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ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2005 29471 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:10 PM KOHN SEPTEMBER 2005 ALVIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner +rospiTAL RANDALLSTOWN BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months 212-20-6885 81 08/31/1924 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Moderal Examiner reserves once. 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No MD BALTIMORE OWINGS MILLS Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8000 VALLEY MANOR ROAD APT. #2B U.S.A. 21117 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) SALES LIOUOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be MICHÁEL KOHN DORA GOLDBERG 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BEVERLY KOHN / WIFE 8000 VALLEY MANOR RD APT.2B OWINGS MILLS MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ABurial 2 ☑ Cremation 3 ☑ Removal from State Date 5 Other (Specify) OHEB SHALOM MEMORIAL 09/08/2005 REISTERSTOWN, MD 4 ☐Donation uneral Service L 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION ACUTE YOCARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 2 **P**No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 172 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SEPTEMBER 2005 D54352 MIRCEA TODOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RANDALLSTOWN MD 21133 +COSPITAL OLD COURT ROAD 5401 MORTHWEST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 2005 G

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 15 29472 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7, 2005 3:50 Catherine May Loveless September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Health Services Rossville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2√5 220-22-7853 Director 89 July 10,1916 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-1 show traumatic event, the Medical Examiner must be notified at 1 Tyes 2000 Director Marvland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö U.S.A. 615 Boxelder Drive 21040 Itams 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itam any injury or other traumain. Black, White, etc. 1 ☐ Yes **②**(XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie May Stonesiefer William Ambrose Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 615 Boxelder Drive, Edgewood, Maryland 21040 Dorothy Hanssen (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard Sept. 10, 2005 Baltimore, Maryland ' 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ski Funeral Home, P.A. 21. Signature of Fundral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) HYPOXIA **Physician** /Medical Examiner MYOCKRDIAL INKARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Dav Year for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ NO P.O. detached the 9 Unknown bed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à sign. AlzHange's DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CORONARY ARTERY 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performed? 2 No 1 Tyes Division of Vitai Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4 Harsing Home 5 Residence 6 □Other (Specify) 2 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending F s after death. I Diractor: After Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Dode 10 D55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DENNIS H. EDIE 9106

31. Date filed (Month, D. Year) 0 9 20052. Register's Signature

PAHILADELSHIA

1 posti

Julie 200

			For State Registrar	State of Maryland		Health and Mental	/	29473
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Waters	Certificate of Lich+	2. Date of Month	of Death Day Year	3. Time of Death
>	/Medic Examin		4a. Facility Name (If not institution, give str			or Location of Death	4c. County of Dec	ath
	Funeral Director		216-11-951/	7. Age (In yrs. le		More City Hours Min. B. Date (Mont) July	of Birth 9. Bi	M/A Ithplace (State or Foreign outry) Limore, MD.
	yland now		Usual Residence of Decedent 10a. State 10b. County		, Town or Location			10d. Inside City Limits
	he Mar 8a-f sh otiffed	ector	Maryland Baltimore	County To	owson		10g. Citizen of What C	1 ☐ Yes 2 ☑ No
	3a or 3	וַם	10e. Street and Number 509 E. Joppa Road		10f. Zip Code	204	United S	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Madical Examiner must be multiled at	by Funeral Director		. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2♥ No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify Yes of the American, Puerto Rican, etc.) Specify:	or No- 14. Race - Arr Black, Wh Specify: [V]	ite, etc.
21215-0036	72 hou natura	Completed by	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Decedent's Usual Occu (Give kind of work done	pation during most of working	16b. Kind of Busines	s/Industry
121	filed withln Hygiene. Ithar than "I	ompl	Elementary/Secondary (0-12)	College (1-4or 5+)	Viife. DO NOT use retire Unemplo	•	Unemp]	.oved
Maryland 2	ould be filed Mental Hygi arked othar	To Be C	17. Father's Name (First, Middle, Last) Helmut Friedrich Li			18. Mother's Name (First, M Margaret Wate	iddle, Maiden Sumame)	
Mary	12 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Type Mrs. Margaret Licht			tand Number or Rural Route N se Ave. Apt.A		
Baltimore, I			20a. Method of Disposition 1 Burial 2 Ceremation 3 Rer 4 Donation 5 Other (Specify)	20b. Pl	lace of Disposition (Name of emetery, crematory or other plans Funeral Characters)	Date	20c. Location - City of	r Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	Jair, Sr.	eaceful ^{Ad} 2325 York	Tternatives Fu Road Timonium,	neral&Cremati Maryland 2	on Ctr.,P.A.
N.	Pnysician		23a. Kan1. Enter the decase, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition	tions that caused the death cause on each line.	n. Do not enter the mode of dy	ing, such as cardiac or respirat	ory arrest,	Approximate Interval Between Onset and Death
1760, 5	/Medical Examiner	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Earlier Undarying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a conseque	uence of):			
.O. Box 68	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pregnand	су	23d. Date of d Month	elivery Day Year
<u>α</u>	quires that n signed build be deta	by	Part II. Other significant conditions control Hodakins Lympho.	ibuting to death but not resu Ma ESChe	ulting in the underlying cause gr	iven in Part I. 23e.	Did tobacco use contribute 1 ☐ Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
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Vital	Physician: this certificated director, i	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Nopatient 2 1	ER/Outpatient 3 □ DOA	26. Place of Death (Check other:	nnly one) Residence 6 Other (Sp	ooifu)
of	Attending Physic death. actor: After this by the tuneral d	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Injury Wo		ribe how injury occurred	вспу)
Division	를 하는 다	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office		ion (Street and Number or F or Town, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical (29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	r: On the basis of examinat and manner stated.	wledge, death occurred at the t tion and/or investigation, in my	time, date and place, and due to opinion, death occurred at the	the cause(s) and manner a time, date and place, and de	as stated. ue to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			se number	29d. Date signed (Mor	
			1 W . E !	alotted agus at 1 in in	<u> </u>	-64383	September	0,2005
	- 1		William B. Greenor	oh III, MU	5505 Hop	-04383 okins Bayvie	w Circle Bo	11 more 2122
6	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 9 2	32. Registrar's Signal	ture of facility			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2005 29474 1- State Amend item #28a, b&f Per Me GRAFFICATE OF POST THE 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2005 LLOYD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Marylans Med ch. Baltimone n/a UNIVERSIT OF If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 □ F Yrs Maryland Sept 11, 1954 Director 213-64-0338 50 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir then "naturel", or freme 23a or 28a-f ehow tre Medical Examinar must be notified at 1 ☐ Yes 2 XNo Directo Severn Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21144 1177 Delmont Lane Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ∐Yes 2∭XNo fYes, Give 1 ☐ Never Married 2 Marned 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 þ White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 I Hygiene. other then "n Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 11th 12 should be filed w and Mental Hygie 7 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dick Ann Peggy Melvin Pau1 Lloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 ie m any injury or other traum 1177 Delmont Lane Severn, Maryland 21144 Jean Marie Lloyd/ wife 20b. Place of Disposition (Name of Epiphany Cremetory of the place Church Cemetery Date 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/10/2005 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee Thomas M00957 ianta (r 1411 Annapolis Road Odenton, Maryland 21113 23a. Part.) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner MOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last consequence of) Examiner burial-transit dia led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL STAMIN e Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of deliver 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete has autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 Napatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 8/26/05 5 Pending investigation 1 Natural VS. 1 Yes 2 No Motor Vehille with 5 unk 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8115 Hearns Pond Rd 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Race track Seaford, De. Hospitel 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier within 24 hor To the Fune (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D.D.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SEP 0 9 2005

nomas

s of person who g

30. Name and addre

32. Registrar's Signature

empleted cause of death (Item 23a) (Type, Print)

ORIGINAL

			1- For State of M	Maryland / Department of Health and Mental Hygiene 0 0 5	29475
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) HARLES 4a. Facility Name (If not institution, give street and number)	LUND SR. Sept 8. Zeo.	
	Funeral Director	ier	MERCY MEDICAL 5. Social Security Number 6. Sex 7. A 24-32-5666 Usual Residence of Decedent	Ge (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. May 1, 1736 R.	thplace (State or Foreign or Mark)
	death with the Maryland ms 23s or 28s-1 show	Director	10a. State 10b. County MARYING 10e. Street and Number	10c. City, Town or Location 13A 1+1 MOSC 10f. Zip Code 10g. Citizen of What C	10d. Inside City Limits 12 Yes 2 □ No
	er death with tems 23s or	Funeral Di	11. Marital Status 12. Was Decedent Armed Forces	AULUYC 2/24 U.S. It Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Am. Rlack Whi	A - erican Indian,
5-0036	72 hours after naturel', or Ite	by	1 ■ Never Married 2 Married 1 Yes 2 ■	No 1 ☐ Yes 3 ☑ No Specify: Specify: 16a Decedent's Usual Occupation 16b Kind of Rusiness	hite
2121	filed within Hygiene. other then "	e Completed	Elementary/Secondary (0-12) St 17. Father's Name (First, Middle, Last)	(Give kind of work done during most of working life. DO NOT use retired) Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame)	Steel
Maryland	should be and Mental Is marked c	To Be	Frank 19a. Informant's Name/Relationship (Type, Print)	LUND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,	C/C Zip Code)
-	ages 1 and 2 int of Health t: If item 27 I y or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or	21224 Town, State
Baltimore	permit. Par Departmen Importent: any injury once.		21. Signature of Puneral Service Library	BAYNICU CREMATONY 9-13-05 SATE. M 22. Name and Address of Facility ZANNINO LICENSED P.G. BOX 23942 BAILD 21	MRYLAND HORTICIAN 203
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	ad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line.	Approximate Interval Between Onset and Death
V 00	Examiner	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. L	S a consequence of): ADDER CANCER s a consequence of):	DAYS MONTHS
.O. Box 68760	death certific e attending p id for use as	Physiclan/Medical		e of pregnancy 2	ivery Day Year
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Vital Record	iicien: The law r certificate has be rector, page 2 sh	Completed		24a. Was an autopsy performed? 1 ★ Yes 2 □ No 1 □ Yes	topsy findings available completion of cause of
ō	d s	on; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No 1 No Hospital: 1 Inpati 27. Manner of Death 1 Natural 5 ☐ Pending	ury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Work?	cify)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inbuilding, ei	ijury - At home, farm, street, factory, office tc. (Specify) 28f. Location (Street and Number or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funerel I completely filled	edical	one) and manner st	of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due tated.	stated. to the cause(s)
)	To To	×	29b. Signature and title of certifier **Constitution of Certifier** **Constitution of Certifier* **Constitutio	29c. License number 29d. Date signed (Month 2 M.D D0063326 SEPT 9	2005
	6	• 0	30. Name and address of person who completed cause of or KUSH DMOLAKIA 31. Date filed (Month, Day, Year) 33. Registr	MERCY MEDICIAL CENTER BALTIM	IONE MD
	Sta Registr		SEP 0 9 2005	rar's Signature	

			1 - For Amend Item Registrar				eaith and M Death			
j.	Physici /Medic	_	Decedent's Name (First, Middle		Cook Levit Mary Levit			2. Date of Deal Month Septe	Day Year mber 2, 2005	3. Time of Death 1:20 р м
	Examir		4a. Facility Name (If not institution	n, give street and number) Gilchrist Hospice		4b. City, Town, or	Location of Death Balt	imore	4c. County of Deal	more City
	Funeral Director	1	5. Social Security Number 254.80.2939	6. Sex 7. Ag	ge (In yrs. last birthday, 48 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, January 31		hplace (State or Foreign buntry) Illinois
	ylend		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or L	ocation			·	10d. Inside City Limits
	he Mar 8a-1 s	Director	Maryland	Howard			arksville	1.	0. 0.	1 Yes 2X No
	3s or 2		10e. Street and Number 5801 Clipper Lane:	Unit 103		10f. Zip Code	21029	'	0g. Citizen of What Co	S.A.
336	filed within 72 hours after death with the Marylend Hygiene. ther then "natural", or items 23s or 28s-f show ther then "natural", or items to profiled at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorces	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give	?	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🔀 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
215-0036	vithin 72 hounder. Ne. han "natura e Medicul E	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired,	luring most of worki.)	ng	16b. Kind of Business/ US Go	Industry overment
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lan	should be nd Mental marked o	To Be		Hugh Cook				Fran	ices Melcher	
Man	12 sho		19a. Informant's Name/Relations		,				, City or Town, State, 2 , Maryland 2102	
	ges 1 and 2 should t of Health and Men if Item 27 is marke or other traumatic		Mr. Lore M. Lev 20a. Method of Disposition		20b. Place of Disp				20c. Location - City or	
Baltimore,	Pages ment of ant: If it ury or o		1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			bia Memorial F	na//	09/2005	Clarksville	e, Maryland
Ball	perr it. Pag Department Important: I any injury o		21. Signature of Funeral Service	Liefinsee	2		uneral Home.			
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	/Medical Examiner		12	Due to (or as	onary 0 sa consequence of): 25 khic 6	2reast	Cancer			yens
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_			IF FEMALE:	23c. If yes, outcome	a of prognancy					102
.O. Box	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	1 Uve birth 4 Pregnant a	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	w requires that s been signed t should be deta	þ	Part II. Other significant conditi	ons contributing to death t	but not resulting in the u	underlying cause give	n in Part I.	23e. Did tob	oacco use contribute to es 2 □ No 3 □ Pr	the cause of death?
Vital Records,		Completed						24a. Was a autops perform	y prior to death?	itopsy findings available completion of cause of 2
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 → No	Hospital	ent 2 ER/Outpatie	ont 3 DOA Othe	26. Place of Death			city) hospico
Division of	ding After	ation; To	27. Manner of Death 1 Anatural 5 Pendi	28a. Date of Inju		of 28c. Injury Work	4 🗆 Hursing Hor		ow injury occurred	chy) vos pop
Divis	tel or Attend s efter deatl el Director: ed in by the	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of In	jury - At home, farm, st tc. <i>(Specify)</i>	treet, factory, office	=======================================	28f. Location (St City or Town	reet and Number or Ru n, State)	ıral Route Number,
	To the Hospital or A within 24 hours effer To the Funeral Directorplately filled in by	edical	(Check only 2 Medical one)	ng Physician To the best Examiner: On the basis of and manner st	of examination and/or in	nvestigation, in my op	inion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
•	with To	W	29b. Signature and title of certific	ales		29c. License	5303		9d. Date signed (Monti	ec 2, 2005
	25		30. Name and Iddress of person	Craver in	2 6601 N	Print) Charle	S St 70	wsav.	MO 21204	1
	Sta Registi	_	31. Date filed (Month, Day, Year,	32. Regist 0 9 2005	rar's Signature	both				

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg NO 0 0 5 0 0 7 7 7
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death
	Physici /Media		Patricia Langley September 4, 2005 8:05Am
}	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			NOVEMBER HOSPITAL CONTEX KANCALLS TOWN BALLIMOVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholane (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MD 9. Birthplace (State or Foreign Country) MD
	pu ,		Usual Residence of Decedent
	faryla shov	ō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Randallstown 1 ges 2 page 1
	the N	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Majical Examirer must be rediffied at	ai Di	3544 Carnage Hill Circle Apt. TZ 21133 USA
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 BeNo 3 □ Widowed 4 Benovorced Year or Dates: 1 □ Yes 2 Beno 1 □ Yes 2 Beno Specify: Specify: Specify: Black
21215-0036	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry
21	within 7 iene. than "r	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)
121	be filed within 72 hours after death with the Marylar tal Hygiene. Id other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event. It a Medical Evandret must be rediffed at		17. Father's Name (First, Middle, Last) College (1-4 or 5+) Private Nurse Healthcare 18. Mother's Name (First, Middle, Maiden Surname)
Maryland		To Be	Nathaniel Langley Vida Ashford
Man	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship Toe, Int) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Preston, Iv. /Son 144 Muybin Circle Dwings Mills MD 21117
	1 an Heal em 2 ther		20a. Method of Disposition 20b. Place of Disposition Name of competing a Demonstrate Competency of other place) 20c. Location - City or Town, State
ino	Pages nent of ant: If it ury or o		1 DeBurial 2 Cremation 3 Removal from State Ling Park 19.09.05 Randall Stown, MD
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services 515NBaitmore Nat 1 Pike Balto. MD 21229
	402.00		23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dving such as cardiac or respiratory arrost
	Pnysician		Immediate Cause (Final Constant and Death Constant
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):
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J	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. Due to (or as) onsequence of): c. Due to (or as) onsequence of): c. Due to (or as) onsequence of):
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8760,	cate be executed physician and the buriat-transit	dicai	d.
39 ×	death certific	/Med	IF FEMALE:
Вох	attene attene	cian	23b. Was decedent pregnant in the past 12 months? 1
0	that the de ed by the detached	Physician/Me	1 ☐ Yes 2 ☐ MG 4☐ Pregnant at time or death 5☐ Other (specify)
S, P	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ord	w requir been si should		CVVOVIC 1019 alsale 1 Yes 2 No 3 Probably 4 Bonknown
Vital Records,	has b	Completed	24a. Was an autopsy findings available prior to completion of cause of death?
		e Co	1 Yes 2 THO 1 Yes 2 THO
	Q 50	To B	26. Place of Death Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 No Norsing Home 5 Residence 6 Other (Specify)
	ding Phys The this funeral di	ou:	27. Manner of Death 28a. Date of Injury 28b. Time of 1 Sec. Injury at 28d. Describe how injury occurred Work?
Division	Attending r death. ector: After by the fune	icati	2 Accident investigation M 1 Yes 2 No
Ο̈́	after after Direct d in by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or investigation in my opinion death accurred at the time, date and place, and due to the cause(s) and manner as stated.
	the Ithin 24 the F	Medical	one) and manner stated.
	M V V		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
_	U		Evica Tobin Muldrow, MD 5401 Old Court Road Roundallstrum
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature ////////////////////////////////////
	Registra	all K K	SEP 0 9 2005 December 1

		1 - For State Registrar	State of Marylan	a / Depa <i>Cei</i>	artment of F <i>tificate of</i>	dealth and N <i>Death</i>	nental Hyg	iene 200	15 2947
ysici	an.	1. Decedent's Name (First, Middle, La					2. Date of Deat	h	3. Time of Death
Medic	al	Gerald D. 4a. Facility Name (If not institution, giv	Lahti		Ab Ciby Tourn	or Location of Death	Septembe		
camin	er _	Stella Maris Ho				nonium		4c. County of D Bal	timore
eral ctor		389-40-7135	ex 7. Age (In yrs. ☑ M 2□ F 57	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC • 07	⁴ 947	Birthplace (State or Foreign Country) W I
del	_	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
event, tra Medical Examinar must be notified at	Director	Maryland Anne 10e. Street and Number	Arundel		10f. Zip Code	asadena	10	g. Citizen of What	1 Yes 2 No
D IST	raiD	1232 Lorene Driv				21122		US	SA
	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marned	12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of F Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
	by	3 Widowed 4 Divorced	1 🕅 Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐ Yes 2💢 No	Specify:		Specify:	White
	eted	15. Decedent's En (Specify only highest gra	ducation de completed)	16a. Deced	ent's Usual Occup	pation during most of work	100	6b. Kind of Busine	ss/industry
Name of the last o	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	<i>NOT use retire</i> Analyst	d)	9	NSA/Ft.	Meade
	Be C	17. Father's Name (First, Middle, Last,				18. Mother's Name	_		,
	To		ahti			Viola	I.	Mackie	
	1	19a. Informant's Name/Relationship (Гуре, Print) (SDOUSE)			and Number or Rura Drive, Pa			e, Zip Code)
		Linda Lahti 20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of		Date 2	Oc. Location - City	or Town, State
.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (S	Heilioval Holli State		Veterans	ocpo.	07		le, Maryland
ony injury or our		21. Signature of Fun - Service Liver			Name and Addre				Home, P.A.
ä		23a. Part1. Enter the disease, or com shock, or heart failure. List only	21.			ntain Roa	d, Pasad	ena, MD 2	
	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. METASTATIC Due to (or as a consequence) b. Due to (or as a consequence) c. Due to (or as a consequence)	uence of):	EAL CANC	ER			
for use as the b	Medi	IF FEMALE:						300	
	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
	۾	Part II. Other significant conditions o	ontributing to death but not resu	ilting in the un	derlying cause give	en in Part I.			to the cause of death? Probably 4 X Unknown
leo eg pinous y ef	ete						-		
	Completed						24a. Was an autopsy perform	ed? prior t death	
	Be	25. Was case referred to medicat examiner?	Hospital:		Out	26. Place of Death	Check only one		
	Certification; To	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Work	4 Nursing Hor	ne 5 ☐ Residen 28d. Describe how	ice 6 M Other (S _P v injury occurred	pecify) HOSPICE
	ertit	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office	2	28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowiner: On the basis of examinat and manner stated.	vledge, death ion and/or inve	occurred at the timestigation, in my of	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	ise(s) and manner e and place, and d	as stated. ue to the cause(s)
	×	29b. Signature and title of certifier			29c. License	3725	290	d. Date signed (Mo	nth, Dey, Year)
		30. Name and address of person who			,			1 -1	
		DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)	OD 2300 DULAN 32. Registrar's Signat	EY VAL	LEY RD.	TIMONIUM,	MD 2109	93	
Stat	e	SEP 0 9	oz. Hogistiai s oigilat						

			For State Registrar		epartment of Health and M Certificate of Death	lental Hygien Reg. N		29479
	Physic		1. Decedent's Name (First, Middle, Last)	E. Mucohu		2. Date of Death	Day Year D	3. Time of Death
	/Med Exami		Itlant. Like	net and number)	4b. City, Town, or Location of Death	4	4c. County of Death	<i>y</i> . 30:
E L	Funeral Director		214-90- 2442	7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea		ace (State or Foreign ry)
	iryland show		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	1 1 1		10	d. Inside City Limits
Λ Ο	h the Ma r 28a-f s	Director	10e. Street and Number	Bo	altimore 101. Zip Code	10g. C	Citizen of What Countr	1 PYes 2 □ No ry?
22	leath witi ns 23a o mast be	Funeral D	2211 W. Roger	Was Decedent Ever in U.S.	21209 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - America	ın Indian,
	ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f show event, the Medical Evanfror must be inclified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 D No Specify:	Rican, etc.)	Black, White, e	tc.
5	15-UU36 n 72 hours aff "natural", or	Completed	15. Decedent's Educat (Specify only highest grade of	ion 16a. Do	ecedent's Usual Occupation Give kind of work done during most of work le. DO NOT use retired)	ing 16b.	Kind of Business/Indu	ustry
	ed within ygiene.	Сошр	Elementary/Secondary (0-12)	College (1-4or 5+)	edit Office	14	-echt C	ე
JY O	aryiand 212 should be filed within and Mental Hygiene. smarked other then umatic event, the M	To Be	17. Father's Name (First, Middle, Last)	oks	Rosa	e (First, Middle, Maide H. Hu	emphices	15
	Ma nd 2 : iith ar 27 is r trau		19a. Informant's Name/Relationship (Type,	(Print) 196. M	lailing Address (Street and Number or Run	al Route Number, City	or Town, State, Zip	10de) 1D 20764
ح ص			20a. Method of Disposition 1	noval from State cemetery,	crematory or other place)	Date) 20c.	Location - City or Tow	vn, State
Mag	Baltimore, permit. Pages 1 ar Department of Hea important: if itam any injury or otha		21. Signature of Funeral Service Licensee	Harkux	22. Name and Address of Facility	CTIMORE		7.
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	tions that caused the death. Do not pause on each line.	EVHAS FUNERALCH enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
•	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CEREBROVASC Due to (or as a consequence of):	CULAR ACCIDE			Onset and Death WEFK
	Examiner	_	Sequentially list conditions, if any, leading to immediate	HYPERTENSIVE Due to (or as a consequence of):	CERLIBROVASCULAR	DISCASO	= }	1 GARS
	60, control of the sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ESSCNTIAL Due to (or as a consequence of):	HYPERTENSION			YEARS
	the cate	dicai	L d					
	Box 6 leath certific attending p	Physician/Me	IF FEMALE: 23c Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of deliver	y Day Year
	that the de sed by the a	Physic	1 ☐ Yes 2 MNo 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)	CO. Didash		4 4-142
	COTGS, F requires that been signed should be de	b	Part II. Other significant conditions contributed in SULIN-DEPUNDENT	•			o use contribute to the	
!	VITAI HECOTIS, P.O. BOX 6 sician: The law requires that the death certificate has been signed by the attending I lirector, page 2 should be detached for use as	Completed				24a. Was an autopsy performed?	prior to com	sy findings available pletion of cause of
	OT VITA Physician: r this certifice rai director, I	Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Outpa		h (Check only one)	6 ☐Other (Specify)	
,	On of VITa ding Physician: After this certific funeral director,	ion: To	27. Manner of Death 1. Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	e of 28c. Injury at	28d. Describe how in		
	VISIC Attanc r death ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Street: City or Town, Sta	and Number or Rural ate)	Route Number,
	DIN To the Hospital or within 24 hours afte To the Funeral Dir.	Medical C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	ian: To the best of my knowledge, or: On the basis of examination and/or and manner stated.	leath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as sta and place, and due to	ted. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	D0 "D	29c. License number		Date signed (Month, D	
	(30. Name and address of person who com	pleted cause of death (Item 23a) (Ty	D-19425 ROGERS AVE- B	01	- 40-	2
	り s	tate	ROBERT E. ROBY 31. Date filed (Month, Day, Year)	3.3	KOGERS AVE- 13	ALTIMORE	עוין ד	1/207
	Regis		SED A G 2	005	BORALES			

			1 - For State Registrar	State of Maryla		artment of H			giene leg. No 20 (05 29480
	Physic /Medi Exami	cal	4a. Facility Name (If not institution, give	Moses	1 -	4b. City, Town, or	Location of Death	2. Date of Dea Month	Day	Year 1133 AM of Death
	- Funeral	8	University of Marylan 5. Social Security Number 6. Se	rel Medical Ce	. last birthday)	Boutin If Under 1 Year Months Days	Il Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthplace (State or Foreign Country)
	Director Model		Usual Residence of Decedent 10a. State 10b. County	. 36	Yrs.			10/26	1946	SC 10d. Inside City Limits
	with the Mar a or 28a-f el	Funeral Director	MD NA 10e. Street and Number		ltimo	Ce 10f. Zip Code		1	0g. Citizen of W	hat Country?
21215-0036	hours after death with the Maryland tural; or Itema 23a or 28a-f show al Eventher must be profitted at	by	2511 West Lafa 11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	Yette Aye 12. Was Decedent Ever in L Armed Forces? 1√3 Yes 2 □ No If Yes, Give Year or Dates:	1	2121 Was Decedent of Hi i Yes, specify Cuba	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	S.A. American Indian, K. White, etc. Black
215-	within 72 h ene. than "natu he Medica	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Deced (Give life, L	lent's Usual Occupa kind of work done o OO NOT use retired,	ation furing most of works)	ng	16b. Kind of Bus	iness/Industry
nd 21	e filed Il Hygi other	Be Com	12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+) na	Po	olice Of	ficer 18. Mother's Name			of Maryland
Maryland	d 2 should by th and Ments 7 is marked traymatic ev	5	W. C. Leggett 19a. Informant's Name/Relationship (T)	rna Print)	10h Mailia	- 144 (6	Sallie			
Baltimore, Ma	es 1 and 2 of Health a fitem 27 is r other tra		Linda Moses-Wife 20a. Method of Disposition Burial 2 Cremation 3 F Donation 5 Other (Specify)	20b. Flemoval from State	251 Place of Dispos cemetery, crem	g Address (Street a West L sition (Name of latory or other place	afayett	e Ave,	Balto	
Baltir	permit. Pag Department Important: I any injury o once.		21. Signature of Fungral Service Licens		22	lle Vet Name and Address arch F/H 800 Waba	s of Facility	2000		ille, Md
8760,	Cate be executed by Sician and Examiner strength frankly transit support transit support to the private support to the private support to the	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence). Due to (or as a consequence).	uence of): uence of):	1 /	i, such as cardiac o	i respiratory arre	nore, P	Approximate interval Between Onset and Death
.O. Box 6	The law requires that the death certific tie has been signed by the attending p age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of degree Unknown	ideath 3 □i	Ectopic pregnancy Other (specify)			23d. Date of Month	*
Records, P.	w requires that been signed b should be deta		Part II. Other significant conditions con	tributing to death but not resi	ulting in the un	derlying cause giver	n in Part I.			ute to the cause of death?
		e Completed	25. Was case referred to medical	- 10-				24a. Was an autopsy perform	prio ed? dea No 1 [ore autopsy findings available or to completion of cause of ath? Yes 2 \sum No
	S 20	To Be	examiner?	ospital: 1 X Inpatient 2 🗆	ER/Outpatient	0.4	26. Place of Death 4 ☐ Nursing Hom			(Specify)
Division of	ing After	Certification:	27. Manner of eath 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. ate of Injury (Month, Day Year)	28b. Time of Injury		at 2 es 2 No	8d. Describe hov	v injury occurred	
Ö	2 4 5 5		4 ☐ Homicide determined 29a. Certifier iX Certifying Physics	28e. Place of Injury - At ho building, etc. (Specify ician: To the best of my known and the control of the cont	vledge death	Occurred at the time	data and place a	City or Town,	State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Modical Examin one)	er. On the basis of examinat and manner stated.	ion and/or inve	estigation, in my opir	nion, death occurre	d at the time, dat	use(s) and manne le and place, and	ar as stated I due to the cause(s)
	£ ₹ £ 5	W	29b. Signature and title of certifier Ways	SKARE		29c. License	-21		alula	Month, Day, Year)
	Sta	te	30. Name and address of pe, on who con 31. Date filed (Month, Dal, Year)	npleted cause of death (Item 32. Registrar's Signat	23) (Type, 8	rint)	/ medica	l Cnt.	JJ S. C Bastino	c, ml disej

State of Maryland / Department of Health and Mental Hygiens, 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** September 2145PN Mellette 2005 Dorothu М. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BaltinoRe Social Security Number 8. Date of Birth (Month, Day, Year) 03.25.1931 Birthplace (State or Foreign Country) If Under 1 Year If Linder 24 Hrs 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 74 Yrs. 248.50.7264 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Item 27 is marked other then "natural", or Itema 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Baltimore MD 1 XVes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Grove St. # 11K 740 Popular USA 21216 by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Domestic Homemaker 12th arade 18. Mother's Name (First, Middle, Maiden Sumame) UNK 17. Father's Name (First, Middle, Last) Caldwell Daisu Daniel 19b. Mailing Address (Street and Number of Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3011 W. Lanvale St. Baltimore MD 21216 Cynthia Mellette 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1
Department of H
Importent: If itel
eny injury or oth Baltimore, MD 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 09.09.05 Baltimore Nat'l 4 ☐ Donation 5 ☐ Other (Specify) 22. Name, and Address of Facility Vaughn C. Greene Funeral Sentices 5/5/Balto. Nat Dike Bouto MD 21229 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis 8 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pneumonia Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner this certificate has been signed by the attending physicien end at director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Wellette, Dorothy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus Diabetes 1 Yes 2 No 3 Probably 4 Unknown failure 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No stage renal 2 No 1 Yes 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Alter Injury 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after deati To the Funeral Director: completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 21229 MO Michelle Henggeler. 900 caton Avenue, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 0 9 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day September 3, Ester Ruth Messenger 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilcrest Center Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 78 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 25, 1927 Birthplace (State or Foreign Country) **Funeral** 1 M X F 214-20-2516 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1229 Wall Street 21230 23a USA or Items : 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 240 No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Production Line Manufacturing Paint 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orval Ford Gertrude Betterbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street, August Messenger, Sr. 1229 Wall Baltimore, MD 21230 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Sept. 6 Baltimore, MO 21. Signature of Funeral Service Ocense, 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain kd., Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancel Montes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence & Other (Specify) NOS PCCO Certification: To 1 ☐ Yes 2 PNo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Japital 4 hours after dee...
real Director: After 12 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Y Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 58303 September 3 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, an Zizoy N. Charles (T AARUN Charales uno 6601 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State 0 9 2005 Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - For S Registrer	tate of Maryla	nd / Depa	artment of H	ealth ar Death	nd Menta	al Hygie	ene 2 0	05	29483
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Da	ite of Death	Dav	Vear	3. Time of Death
,	/Media	al	Josephine Hele 4a. Facility Name (If not institution, give street		CK1	4b. City, Town, or	l agation -4 f		tember	4c. County	2005	12:18 AM
	Examir	er	757 201st Street	and numbery			sadena				e Aru	ndel
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mi	te of Birth onth, Day, Y			ace (State or Foreign
	Director		213-14-7547 1 M	2 A 1	84 Yrs.			Mar	onth, Day, Yo	1921		MD MD
	ryland how		10a. State 10b. County	10c. (City, Town or Lo	cation					10	d. Inside City Limits
	he Ma 8e-f	ecto	Maryland Anne Aru	ndel			sadena					1 ☐ Yes 2 X No
	Sa or 3	Funeral Director	757 201st Street			10f. Zip Code	21122		10g.	. Citizen of W I	/hat Count JSA	ry?
	eme 2	nera	11. Marital Status 12.	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba		n? (Specify Ye	es or No-	14. Race	- America	
36	safter , or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates:		_	Specify:	r dello rican,	ecc.)		k, White, e Whit	
9	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Iteme 23a or 28e-f show ont, Its Medical Examinational by nutified at	ted t	15. Decedent's Education	on	16a. Deced	dent's Usual Occupa	ation		168	b. Kind of Bu	siness/Ind	ustry
2	ithin 7 Je. Jen "n	Completed		mpleted) College (1-4or 5+)	(Give life. I	kind of work done d DO NOT use retired,		f working				,
8 2	Hygier Hygier ther th	Col	12 17. Father's Name (First, Middle, Last)			Salesper		Name (First,		epartr		Stores
<u>a</u>	lid be fental rked o	To Be	Francis Kopec				Mary	, ,		lowski	7/	
lary	2 should and Men ie marke eumatic	•	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	nd Number o	or Rural Route	e Number, C	ity or Town, S	State, Zip (Code)
e)	1 and Health em 27 ther tr		Theresa Mayne (d	aughter)	757 Place of Dispo	201st Sti	reet,	Pasade Date	na, MD	21122 c. Location - 0	City or Tay	m Ctata
D D	Pages nent of I int: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemetery, cren	natory or other place en Cemeter		ept. 0	19		-	Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Iteme 23a or 28e-f show any injury or other treumatic event, the Modeal Examinational be notified at once.		21. Signature of Funeral Service Vornsee			. Name and Addres			1			e, P.A.
-	207 29		Mass	<u> </u>		3111 Moun	tain R	Road, P	asader	na. MD	2112	2
Ь			23a. Part1. Enter the disease, or cor pli ati shock, or heart failure. List only on a c Immediate Cause (Final									Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	CEREB Due to (or as a conse		45 cul	+R	DISE	45E			
	Examiner	_	Sequentially list conditions, if any, leading to immediate									
7	rted	Examiner	Cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):							
۲ 0	ate be executed hysician and the burial-transit	Exar	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):							
8760,		dlcal	d									
9 X	death certifica e attending ph ed for use as t		IF FEMALE: 23b. Was decedent pregnant 23c. (f yes, outcome of pregi	nancy					ood Date	-6 dali	
Box.		Physiclan/Me	in the past 12 months?	1□Live birth 2□Fe 4□Pregnant at time of	tal death 3	Ectopic pregnancy Other (specify)				Mon	of deliver	ay Year
о. О	that the de led by the a	Phys	9 Unknown	9LJ Unknown								
ds,	8 5 9	by	Part II. Other significant conditions contributions	ung to death but not re	esuiting in the ur	iderlying cause give	n in Part I.	23	e. Did tobaco			cause of death?
S	s been sign	olete						24	a. Was an			sy findings available
¥		Completed							autopsy performed Yes 2	j? pr	ior to come eath? Yes 2	oletion of cause of
Vital Records,	iclen: certific ector,	Be	25. Was case referred to medical examiner? 1. Types 2. Who Hosp	ital		lou l		Death (Chec	k only one)			
	ig Phys ter this neral dir	٦.	1 165 2 2 40	Ba. Date of Injury	☐ ER/Outpatient 28b. Time of	3 DOA Other	. 4 ☐ Nursir	ng Home 5	esidence	e 6 Other	(Specify)	
0	anding ath. or: Afte	atlo	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 □ Y	? es 2 □ No			.,,	-	1
Division of	f or Attending Physiclen: after death. Director: After this certification by the funeral director.	ertification;	3 Suicide 6 Could not be 4 Homicide determined 2	Be. Place of Injury - At l building, etc. (Spec		eet, factory, office		28f. Loc City	ation (Street or Town, St	t and Number tate)	r or Rural i	Route Number,
	ours a	O	29a. Certifier 1 Certifying Physicia	n: To the best of my kn	nowledge death	occurred at the time	date and n	lace and due	to the course	2/s) and man		
	T 4 T A	edical	(Chick only 2 Medical Examiner:	On the basis of examinand manner stated.	nation and/or inv	estigation, in my opi	inion, death o	occurred at the	e time, date	and place, ar	nd due to t	ne cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License		2 .		Date signed		
	\circ		30 Name and address of the	MD		1	575	51	34	EP7.	07	2005
		•	30. Name and address of person who completed with the second seco	601 VCG	om 23a) (Type, F	Huy.	Suit	E 204	mi	uera	rille	, MD 21104
	Sta		31. Date filed (Month, Pay, Year) SEP 0 9 2005	32 Registrar's Sign	nature	/						
Ŋ,	Registra	ar :	0 0 2003	Deliver &	A Land	120						

Amend item/24a, perms, com in Alack Indalible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 9 0 5 29484 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September **Physician** Year 2:15 AM 2005 /Medical 4a. Facility Name (If not institution, give street and nu 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Harbor Hospital Center If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, FEB 29 **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F 65 Director 212-36-9405 Yrs. SC Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Wode Item 27 is marked other than "natural", or itams 23a or 28e-1 show other traumatic event, the Medical Examinar must be notified at Director 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2834 Winwood Court 21225 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Ital Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rov Mattison Ophelia Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) perriit. Pages 1 and 2 sh Depirtment of Health and Important: If Item 27 Is m any Injury or other traum 1311 Pentwood Road, Baltimore, MD Deborah Garner - daughter 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Chesapeake Crematory Inc. 9/7/2005 Beltsville, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility CAFA, Stephen D. Lohrmann, 8717 Green Pastures Drive, PA Towson, MD ton 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tractory disease or condition resulting in death) cs than or /Medical Due to or as a consultance of): Examiner hock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ó in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Secondary to Dieulatoy lesio 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed Gastrointestinal Stromat 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an autopsy performed Division of Vital XXYes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide pellij within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) P1778829b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Seyed Motera Furusat, M.D. 3001 S. Hanover, St, Baltimore, M.D 21225 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2005 Registrar

Certificate of Death

4b. City, Town, or Location of Death

Timonium

If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

Reg. No.

2005

4c. County of Death

Baltimore

USA

Specify:

14. Race - American Indian,

White

Black, White, etc.

3. Time of Death

9. Birthplace (State or Foreign Country)
Maryland

10d. Inside City Limits

1 ☐ Yes 2 X No

7:10p M

2. Date of Death

8. Date of Birth (Month, Day, Year) 4/1/14

Sept.

1 - For State Registrar

10a. State

Conrad

5. Social Security Number

174-48-0862

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

Stella Maris

Karl

4a. Facility Name (If not institution, give street and number)

10b. County

Miller

1**X** M 2□F

7. Age (In yrs. last birthday)

Yrs

10c. City, Town or Location

91

Religious Order 18. Mother's Name (First, Middle, Maiden Surname) Barbara Bialek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21042 12300 Folly Quarter Rd. Ellicott City, Md. 20c. Location - City or Town, State Baltimore, Md. Raczorowski facilituneral Home P.A. 201 Dundalk Ave. Baltimore, Md. 21222 Approximate Interval Between Onset and Death 12 ms 23d Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performed? 2 No 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Mora t. Man, 032882 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 32. Registrar's Signature **ORIGINAL**

DHMH 17 Rev 1/2001

within 24 hours at To the Funeral D completely filled in

Medical

State Registrar 4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ROBERT MOSS, M.D.

2005

29a, Certifier

			1- For Amend Items State of Maryland / Department of Health and Mental Hydiene 231, Pt11,25,27 Department of Health and Mental Hydiene 2015 2948	36
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Rebert 2. Date of Death Month Day Year September 5 2005 5.251	
	Examir		4a. Fecility Name ((f not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Day Security Number 9. Birthplace (State or Fo. Months Days Hours Min Hongth Day Year)	reign
	Director		Usual Residence of Decedent	
	Marylan f show	ō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Li	
	or 28e	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	death w	eral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Riack White etc.	
36	72 hours after death with the Maryland neture!', or Items 23a or 28e-1 show Joal Even in arrives be recitized at		1 Never Married 2 Married 1 Yes 2 No Specify: Specify:	
215-0036	72 hour neturel	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 16b. Kind of Bu	
2121	l within iene. r than	omple	Elementary/Secondary (0-12) College (1-4or 5+) Disable	
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28e-1 show other traumatic event. The Medical Exam is per rived to a continuation of the medical Exam is per rived to a continuation.	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Maryland	2 should be and Mental is marked caumatic even	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
_	1 and 2 Health a em 27 is		MANK MILLER 1631 CHANFIELD TERR S.E. PALMBAY, FLORE	9
Baltimore	0 0		20a. Method of Disposition 1 Burial 2 December 2 December 3 Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) 3 Removal from State 3 Constitution 3 Constitution 3	, .
Balti	permit. Page Department o Importent: If any injury or ance.		21. Signature of Auneral Service Licensee 22. Name and Address of Facility 2019 HEDSON ST	
	» — —		23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory wrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Retween	
	Frrysician /Medical		Interval Between Onset and Death disease or condition Solution in death) Interval Between Onset and Death Death Onset and Death De	
	Examiner		Due to (or as a consequence of):	\$
1	nsit %	Examiner	if any, leading to minimulate Due to (or as a consequence or).	
00,	icate be executed physician and s the burial-transit		cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last C. Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER	
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Box	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death states o	
P.O.	that the de ed by the a detached t	hysic	1 Yes 2 No 9 Unknown 9 Unknown	
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al R			Ankylosing Spondylitis, Seizure disorder	of
of Vit	Ø	To Be	25. Was case referred to medical examiner? 1	150
	aling After fune		27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?	
Division	l or Attending after death. Director: After in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide Onknown Onknown Unknown Unknown Unknown Unknown Unknown Unknown Unknown Unknown 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Unknown Unknown Unknown Unknown Unknown Unknown Unknown Unknown Unknown	
Q	spitel o		29a. Certifier To Certifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as attacks.	
	To the Hospitel or Attuwithin 24 hours after de To the Funeral Direct completely filled in by the	Medical	one) and manner stated.	
	T o CO		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 6, 2005	1
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Markinko 5505 Hepkins Bayview Circle, Baltimore Marylund 212:	/
	Sta	9 3	31. Date filed (Month, Day, Year) Registrar's Signature	14
	Registr	ar	SEP 0 9 2005 the starte	

Registrar

State

31. Date filed (Month, Day, Year)

SEP 0 9 2005

3. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

SEP 0 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc 2847 9-9-05 vt. State of Maryland / Department of Health and Mental Hygiene 2005

1 - State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year LILLIAN SARAH ORLOFF SEPT. 4 2005 7:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examinér MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 08/06/1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Days Months Hours Min. 96 203-28-3657 PA Yrs. Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rel', or items 23e or 28e-f shov Exercises investigated at 1 ☐ Yes 2√ No Directo MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 CANTATA COURT 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₺No Specify ð 3 Nidowed 4 □ Divorced "naturel" Completed treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industr (Specify only highest grade completed) CUSTOM MADE WOMENS I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** 12 APPAREL other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and McImportant: If Item 27 1any injury or c." WACHTEL LEON YETTA UNOBTAINABLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERTA SHERIN / DAUGHTER 20 DEER CROSS COURT - REISTERSTOWN, MD 21136 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MT. JACOB CEMETERY 09/07/2005 GLENOLDEN, PA. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service I 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the de this to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical as attending IF FEMALE use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 mos Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No Division of Vital 1 🗌 2 No 1 Tyes Yes the Hospital or Attending Physicien: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. the Funerel Direct á 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 1838 Greene Tree Vel 30. Name and add of death (Item 23a) (Type, Print) h State 9 2005 Registrar

		•	1 - State of Mai		artment of H	leaith and Ment Death		/11115	29490
	-		negistrar Decedent's Name (First, Middle, Last)		1	2. D	ate of Death	Day Year	3. Time of Death
ı	Physicia /Medic	al	Queen		PayN	e sy	tember	5 3005	17:53-P M
	Examin	er	4a.Facility Name (If not institution, give street and number) The Johns Hoplans Hospfil	. /	B. City, Jown, or	Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Da Hours Min.	ate of Birth Nonth, Day, Y	(gar) 9. Birthp	lace (State or Foreign
	Director		519.52.2026 1□ M 2⊠F Usual Residence of Decedent	F Yrs.		, 0	7.05.10	940	VA
	aryland show	ايا		10c. City, Town or Lo				1	0d. Inside City Limits 1.★Yes 2 □ No
	the Ma 28e-1	recto	10- 6141 Number	Baltin	10f. Zip Code		100	g. Citizen of What Cour	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show eny injury or other treumetic event, The Modical Examination of the rotified at once.	Funeral Director	110 North Central Ave. Apt.	411		1202		USA	
	er dea Items	uner	11. Marital Status 12. Was Decedent Evarmed Forces? 1 Never Married 2 Married 1 Yes 2 19 No.	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Y n, Mexican, Puerto Rican	es or No- , etc.)	14. Race - Americ Black, White,	an Indian, etc.
036	ours aft	b	3 Widowed 4 Moivorced If Yes, Give Year or Dates:		1 ☐ Yes 2 StoNo	Specify:		Specify: BO	1ck
15-0	"netur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of working	16	b. Kind of Business/Inc	dustry
212	filed withir Hygiene. Ither then	ошо	Elementary/Secondary (0-12) V2+h ovade College (1-4or 5+) _	ofessional	Singer	E	Entertain	ment
Maryland 21215-0036	be filed ital Hygir d other event,	Be	17. Father's Name (First, Middle, Last) UNK			18. Mother's Name (Firs			
ıryla	2 should be and Mental is marked o	2	19a. I ant's Name/Relationship (Type, Print)	19b. Maili	na Address (Street a	Elizabeth and Number or Rural Rou			Code)
	1 and 2 s Health ar em 27 is ther treu		Heather Payne/Daughter	133 1	Nest 11374	Street, Apt	1 0	New York, N	111111111
Baltimore,	Pages 1 nent of He int: If iten		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State	20b. Place of Dispo		e) Date		c. Location - City or To	
Itim	permit. Pag Department Importent: I eny injury o		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Sundated Fungral Dary, Ali	Greenv	Name and Address	ss of Facility	05_	Bultimore	2 MV
ä	permit. Departr Importe eny inji		Inhall	Ci	remation s 151 Balto.	SOLVICOS -	3a 110 1	UD 212291	
ı			23a. Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	ne death. Do not ent	ter the mode of dying	g, such as cardiac or resp	oiratory arrest	" (hirty	Approximate Interval Between Onset and Death
	Prrysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	Good			18	33min
27	Examiner			2011004201100 017.				True I	
2	led nsit	Examiner	Sequentially list conditions, if any, leading to inhibidiate cause. Enter Underlying Cause (Disease or injury that initiated quarter.	consequence of.			Win	Market	
Ć	execution and rial-tran	Exan	trat initiated events	consequence of):		. 1	or the state of the	10.	
8760,	cate be executed bhysician and the burial-transit	dicai	d			1 25%	4.		
ox e		Physician/Med	IF FEMALE: 23b. Was decedent pregnant			176	4	23d. Date of delive	ary
\mathbf{m}	atte	siclar	in the past 12 months? 1 Yes 2 14 Pregnant at ti		□Ectopic pregnancy □ Other (specify)	- As		Month	Day Year
P.O.			9 ☐ Unknown Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause give	en in Part I	23e. Did tohar	cco use contribute to th	ne cause of death?
Records,	requires tha	Completed by	Cohon Camen, throat	cancer,	heputi	tis C,	1 🗆 Yes		ably 4 Unknown
eco	law asb 2sl	piete	Seizure disonder			2	4a. Was an autopsy	24b. Were auto	psy findings available inpletion of cause of
al B	Th ate pag					1	performe	id?// death?	2[]No
Vital	Physicien: The this certificate har director, page	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 PER/Outpatier	nt 3□ DOA Othe	26. Place of Death (Che Pr. 4 ☐ Nursing Home 5		ce 6 □Other (Specify	/)
n of	g Ph er th eral		27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day)	28b. Time o		at 28d. D		injury occurred	_
Division	Attending r death. ector: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injur	- 17:19A y - At home, farm, str		Yes 2 (1)46 28f. Lo	hulce	and Number or Rura	I Route Number
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	To the Hospitel or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fun	edical	29a. Certifier (Check only (Ch	xamination and/or in	h occurred at the tim vestigation, in my op	e, date and place, and du	ue to the caus	se(s) and manner as st	ated.
	ro the vithin 2 ro the complet	Med	29b. Signature and the of certifier	.d.	29c. License	number	29d	l. Date signed (Month, i	Day, Year)
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	,7		30. Name and addless of person who completed cause of dea	ith (Item 23a) (Type,	Print)	1 BAUTIA	HONE	MA121	1282
	Sta	te	31. Date filed (Month, Pay Sar) 0 200 32. Registrar	's Signature	South of	raspirite C	1001	vo. Wolf	+ >1.
Ŀ	Registr	-	SET U S ZUUD	150 B	CADDINES!				

05-06048 RKD

		1- For Unpend Item 2		per me	illicate 319	5 <u>8</u> 5 <i>ti</i> Fas	Reg	. No.	29491	
Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	h.4	
/Medi	cal	Michael L. 4a. Facility Name (If not institution, give	Pierce		4b. City, Town, or	Location of De	SEPTEMBE	R 4, 200		
Examir	ier	3000 GEORGETOWN RO			BALTIMOR				/A	
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	Month Day Y	9 1	Birthplace (State or Foreign Country)	
Director		217-02-6897	X M 2□ F	22 Yrs.	Mortins Days	Tiodis Will	Sept. 27	7/982	MD	
and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. tnside City Limits	
Mary -f ehc	to	Maryland Anne Ar	undel		P	asadena			1 ☐ Yes 2X No	
r 28a	Director	10e. Street and Number	44		10f. Zip Code		109	. Citizen of What	Country?	
within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23a or 28a-f ehow fra Medical Examinar must be mailliad at	alD	676 211th Street				21122		USA		
er des	Funeral	THE MAIN COURT	12. Was Decedent Ever in l Armed Forces?	J.S. 13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? n, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.	
rs alte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1 ☐ Yes 2 ☐XNo	Specify:		Specify:	White	
2 hou	ted	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occupa	tion	16	b. Kind of Busine	ss/Industry	
thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done d DO NOT use retired,	uring most of w	rorking			
Permit. Pages 1 and 2 should be tiled within 72 hours at Department of Heelth and Mental Hygiene. Them "portent: If Item 27 is marked other then "naturel", or eny injury or other treumatic event, Ira Madical Exambace.	S	12			Labor			Restora	tion	
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thould Me	유	19a. Informant's Name/Relationship (Ty		19b. Mailin	ng Address (Street a		Rural Route Number, C		Zin Code)	
od 2 salth ar 27 ts			andmother)				asadena, MI	-	, <i>Lip</i> 0000)	
permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Department of Heelth and Medical Examiner must be notified at ance.		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		-	c. Location - City	or Town, State	
Page nent c nnt: If ury or		1 🖾 Burial 2 □ Cremation 3 □ P 4 □ Donation 5 □ Other (Specify)		•	en Cemete			len Burn	ie, Maryland	
Departr Departr Importe any inju		21. Signature of Funeral Service License	9/11/	22			Stallings F	uneral	Home, P.A.	
40 E 5 8	2 8	23a. Part . Enter the disease, or compt	Stalling	1			oad, Pasade		21122 Approximate	
icate be executed by the physicien and burial-transit by	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):									
death certif e ettending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 0 \(\text{9} \) Unknown	3c. tf yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	at death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year	
		Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23a. Did tobac	co use contribute	to the cause of death?	
quires tha n signed uld be del	ed by						1 ☐ Yes	2 No 3	Probably 4 Hunknown	
₹ □ ∞	Completed						24a. Was an	24b. Were	autopsy findings available	
The law ate has b page 2 st	mo:						autopsy performe	d? death	o completion of cause of ? es 2 \(\text{\tint{\text{\tin}\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\tex{\tex	
ysician: The lar is certificate has director, page 2	Bec	25. Was case referred to medical examiner?				26. Place of D	eath Check only one	,,		
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After funer	ő	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of trijury 9-4Mo(15 Day Year)	28b. Time of 2:25 y	28c. Injury Work		28d. Describe how	injury occurred	unk	
Attending in death.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of trijury - At I		-	es 2 No	28f. Location (Stree	et and Number or	Rural Route Number -	
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To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	Medical C	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death	occurred at the tim restigation, in my op	e, date and plai inion, death occ	ce, and due to the caus	e(s) and manner	as stated	
To the within 2 To the complet	Me	29b. Signature and titte of certifier	1 11		29c. License	number	29d.	Date signed (Mo	nth, Day, Year)	
		· YM	1. dt		0.0	.M.E.	SE	PTEMBER	5.2005	
		30. Name and address of person who co								
Sta			mpleted cause of death (the	niD	111 PENN	STREET	BALTIMORE 1	MARYLAND		

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s after dec. hin 24 hours a 13

> State Registrar

Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

asha 31. Date filed (Month, Day, Year) 9 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

September, 6, 2005

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

		•	For State Registrar	State of Maryland	•	ent of Health		al Hygiene Reg. No.	711115	29493		
	Decedent's Name (First, Middle, Last)							ate of Death	e of Death 3. Time			
	Physicia		William	J. RhoNe	Se.		SM	onth Day	Year Z	6:05pm		
	/Medic Examin		4a. Facility Name (If not institution, give		4b.C	ity, Town, or Location	on of Death	4c.	County of Death			
			107 Marulas	4D AVENUE		Dundal	K		Balhn	TORE		
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last	birthday) If Un Mont		der 24 Hrs. 8. Da	ate of Birth fonth, Day, Year)		lace (State or Foreign		
	Director		218-26-0628	MM 20 F 74	Yrs.	Days Hou	527	t. 16. 19.	30	"PA		
	P .		Usual Residence of Decedent	40 65 #			/	· ·		04 1-14 07 11-74		
	show	_	10a. State 10b. County		own or Location				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	Be-1	cto	MD Balt	more 1	UNDali	<u> </u>						
	ith th	Director	10e. Street and Number	1	10f.	Zip Code		10g. Citi	izen of What Cour	itry?		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show or other traumatic event, the Medical Examment into the confilted at			land HVENUL		21222			USA			
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Amed Forces?	13. Was De	cedent of Hispanic specify Cuban, Mexi	: Origin? (Specify Y :ican, Puerto Rican	es or No- , etc.)	 Race - Americ Black, White, 			
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Ye	2 No Spec	cify:		Specify: W	1, te		
21215-0036	hour tural		15. Decedent's Ed		6a. Decedent's U	Isual Occupation		16h Ki	ind of Business/Inc	dustry		
ή.	n 72	Completed	(Specify only highest gra	de completed)	(Give kind of	work done during n Tuse retired)	most of working					
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0	filed Hygi other	Ö	17. Father's Name (First, Middle, Last)				other's Name (Firs	t, Middle, Maiden	Sumame)			
an	d be ental ked c	To B	(110112 100)	art.		1	- Ilen 1	Michale				
Maryland	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, the Ms	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr	ess (Street and Nu	mber or Rural Rou	te Number, City o	r Town, State, Zip	Code)		
S	and 2 ealth a n 27 ls		M. agnes Rho	Ne - 111: Po	e-wife 107 Haryland aven					D 21222		
ē,	permit. Pages 1 and 2 Department of Health s Important: If itam 27 lt any injury or other tra		20a. Method of Disposition	20b. Place	e of Disposition (Name of	Date	20c. Lo	ocation - City or To	wn, State		
و ل	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		CREHATORI	3 9/5/2	5 R	16 N	2)		
Baltimore,	nit. F artm ortar injur		21. Signature of Funeral Service/Licer	UVCC	22. Name	7	acility		110,	DA		
ä	permit. Departr Importa any inju		1) Start	(Joseph)	Bra	dky-H	Sh ton F OW Spr	INC DO	1 Home	22		
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. I	Do not enter the r	node of dying, such	as cardiac or resp	piratory arrest,		Approximate Interval Between		
l.			Immediate Cause (Final	C -	11	11 T	0		٨	Onset and Death		
	-nysician ∈ /Medical		disease or condition resulting in death) Due to (or as a consequence of):									
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	11 11 15	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen								
	uted d ansit	Examiner	Cause (Disease or injury that initiated events									
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8760,	cate be executed physician and the burial-transit	d										
9	rtifica ng ph as th	Ned	IE SEMALE.									
Вох	death certific attending plant of for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de		1	23d. Date of delivery					
	that the death ned by the atter detached for i	Physician/Me	in the past 12 months?	4 Pregnant at time of death 9 Unknown				Month Day Year				
P.O.	at the by the	hy	9 Unknown									
	res tha igned be del	by i	Part II. Other significant conditions of	contributing to death but not resulting	art I. 2	23e. Did tobacco use contribute to the cause of death						
ord	w requir been si should	ted						1 Yes 2	□ No 3 □ Prob	abiy 4 Mnknown		
900	e law r has be je 2 sh	ple					2	4a. Was an autopsy	24b. Were autopsy findings availab			
± £ gg Q									death?	21.0No		
Ħ	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?			26. P	lace of Death (Che	ock only one)				
	S S S	2	1 ☐ Yes 2 DNo	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3	DOA Other: 4	Nursing Home	5 Pesidence	6 ☐Other (Specif	y)		
n of	ding Pt		27. Manner of Death 1 Separatural 5 Pending 28a. Date of Injury 28b. Time of Injury 28									
0	Attanding ir death. actor: After by the fune	cati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be a Nove their attention of the control of the c									
Division	r Att ter de iract	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		8f. Location (Street and Number or Rural Route Number, City or Town, State)						
Ω	oltal c											
	To the Hospital or Attanding Ph within 24 hours after death. To the Funarel Diractor: After th completely filled in by the funeral	edical	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	thin 2 thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.	T	29c. License numb	oer	29d Dat	te signed (Month,	Day, Year)		
1	7 × ii		200. Signature and title of certified	\(\sigma_1\).	1	Donles	200	C		. 3		
7	/		" cloud ()"	Jun US		N0018	170	Dep	of Culier	7 000		
	b		30 Name and address of person who	bempleted cause of death (Item 23	1	492W	Courte	DO AVUT.	BANU	4 Zeros		
		t o	31. Date filed (Month, Day, Year)	32. Registrar's Signature	θ φ	, , , –				-		
	Sta Registi		SFP 0 9 2	I I	. Sport	W. Carlotte						
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DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item I per doc 3847 9 0 vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 1 - For State Registrar 29494 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Esther Roach SE 10 Day Year **Physician** 937 A ptembel3200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMO BONSECOURS Ho SPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 X F 219.50.0496 Yrs. MD Director 06.18.1950 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle r than "natural", or Items 23a or 28a-f eho the Medical Examinar must be notified at MD Baltimore ō 1 XYes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hollins Street 21223 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 254No If Yes, Give 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Food Service Manager 12th grade 17. Father's Name (First, Middle, Last) Zyears . Pages 1 and 2 should be filed viment of Health and Mental Hygie tent: If Item 27 Is marked other toury or other traumatic event, Ib other Be 18. Mother's Name (First, Middle, Maiden Sumame) Roach Mollie Lawson Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter / 1944 Hollins St. Baltimore MD 21223 Dionne Burley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 19:10:05 Baltimore W Greenmount 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Vaughen C. Greene Funeral Services
SENBALTIM DR NAT! Pile Balto UD 21229
Approximate 21. Signature of Funeral Service Licensee augh 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IN FARCTO **Physician** m 10CAZD m, with IAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of) Physician/Medicai the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 300 1 Yes 2 11 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ COA Other: ^oL 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation M 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed Box 68760. physician attending p P.0. detached Records, sign 1 be been the funeral director, page 2 Division of Vital Physician: this After or Attending death. 24 hours after deat filled in by completely

death with the Maryland

within 72

Maryland 21215-0036

Baltimore,

Medicai within 2. State

DriJohn Registrar

4 - Homicide

(Check only one)

29a. Certifier

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

D0029968

September 3 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Adkins

2000 West Baltimore Street Baltimore MD

31. Date filed (Month, Day, Year) 32. Pagistrar's Signature 9 2005

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of			giene Reg. N2 0 0 5	29496			
	Physici	an	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	ath Day Year	3. Time of Death			
	/Medic	al .		n Robinso	n	1		Sept.		3:30 p M			
	Examin	er	4a. Facility Name (If not institution, given 17611 Horizon I				or Location of Death		4c. County of Dea				
	Funeral		5. Social Security Number 6. S		e (In yrs. last birthday	Derwo	r If Under 24 Hrs.	8. Date of Birt	Montg	tholace (State or Foreign			
	Director		263-42-7880	□M 2□F	72 Yrs.	Months Days	Hours Min.	(Month, Da Jan 5	y, Year)	w York			
	D		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L					1404 1 14 00 14 1			
	shov	ក	10a. State 10b. County MD Montgo	merv	_ ′′	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No			
	28a-f	ecto	10e. Street and Number	мегу	Derwood	10f. Zip Code			10g. Citizen of What C	21			
	3a or		17611 Horizon Pl	ace			855		United S	•			
36	within 72 hours after death with the Maryland iene. rthan "natural", or Items 23a or 28a-f show it a Medical Examiner must be multiled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces?	1 ☐ Yes 2 ☐ No If Yes, Give		Hispanic Origin? (Speban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Am Black, Whi	merican Indian, /hite, etc. white			
21215-0036	72 ho	Completed	15. Decedent's Ed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work					16b. Kind of Business	s/Industry			
21	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5	ife.		eduring most of working ed)	,,,,					
2	Hygier Hygier ther th		17. Father's Name (First, Middle, Last)			Туре	Setter	(Final Ministra	Print	ing			
anc	t be filed ntal Hyg ed othe sevent,	Be	Herb Wardell	1					Maiden Sumame) Soundry War	đ ₀ 11			
Maryland	hould d Me mark matic	오	19a. Informant's Name/Relationship (Tyne Print)	19h Mai	ing Address (Stree			er, City or Town, State,				
Ma	es 1 and 2 should be f of Heelth and Mental P I item 27 is marked ot r other traumatic ever		James M. Robinso						ver, CO 80				
ē,	is 1 and 2 of Heelth a item 27 is other trai		20a. Method of Disposition		20b. Place of Disc			Date	20c. Location - City o				
Ë	Page nent o nt: if ry or		1 ☐ Burial 2 🌠 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specif			ake Crema		/05	Beltsvil	le, MD			
Baltimore,	permit. Pages 1 Department of H Important: if ite any injury or ot once.		21. Signature of Funeral Service Licer	lymann.	1400382	Rapp Fund 933 Gist	eral and C	rematio lver Sp	n Services	20910			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician		Immediate Cause (Final disease or condition Head and Neck Cancer										
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					1			
		Sequentially list conditions, b.											
		Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury										
	be executed sician and burial-transit	xar	that initiated events c										
8760,	e be e slciar slciar												
9	ificate g phys as the t	edlo		u									
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23d. Date of de Month									
Q	that the seed by detain		Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause g	ıven in Part I.	23e. Did te	tobacco use contribute to the cause of death?				
Vital Records,	luires n sign	d by						1 🕏	Yes 2 No 3 Probably 4 Unkn				
Ö	law require as been si 2 should b	Completed						24a. Was		utopsy findings available			
Re	The ia ate has page 2	E O							osy prior to death?	completion of cause of			
ta		0	25. Was case referred to medical				26. Place of Death	1 ☐ Yes	X	20110			
1	d is	To B											
n of									ow injury occurred				
Sio	Attending r death. ctor: After by the fune	catl	1X Natural 5 Pending (Month, Day rear) Injury Work? 2 Accident investigation M 1 Yes 2 No										
Division	Ital or Attencrs after death ris after death ai Director: led in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						81. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hoscital or At within 24 hours after of To the Functal Direct completely filled in by	Medica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To t To I	≥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
,	d		telseria	ne les		1) 5	1616	1	aptember (06,2005			
	P		30. Name and address of person who			3-10.0	100 686	00. 7-1					
			31. Date filed (Month, Day Year) SEP 0 9 2005										
	Sta Registi		SEP 0	9 2005	La	1							
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			For State Registrar	State of M	aryland / De	partment ertificate			nd Ment	al Hygid	ene 20	05	291	+97
- K 5	Physici /Medi		1. Decedent's Name (First, Middle, Las Robert Ritter	t)					M	ate of Death onth tember	Day	2005	3. Time o	
7	Examir		4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery			
	Funeral Director		5. Social Security Number 6. Si 218-54-6414 1 Usual Residence of Decedent	C7 14 0 -	e (In yrs. last birthda 53 Yrs.	y) If Under Months	1 Year Days	Hours	Min. (M	te of Birth lonth, Day,) y 19,	^(ear) 1952	9. Birthi Cou Mary	place (State ntry) Land	or Foreign
	he Maryland	ector	10a. State 10b. County Maryland Montgome	ery	10c. City, Town or Gaithe	rsburg								ity Limits
nore, Maryland 21215-0036	th with t	Funeral Director	10e. Street and Number 20 Whetstone Drive	e, Apartme	nt 1	10f. Zip	Code 0877					f What Cou d Sta	,	
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sidical Examinar must be notified at	by	11. Maritat Status 1 ☐ Never Married 2 凝 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:		3. Was Decedif Yes, spec		panic Origin Mexican, F Specify:	n? (Specify Y Puerto Rican,	es or No- etc.)		ace - Americack, White,		
	iene. r than	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			cedent's Usua ve kind of work DO NOT us tructio				16		Business/In	dustry y Coll	Lege
	should be filed void Mental Hygie marked other lumatic event, In	To Be C	17. Father's Name (First, Middle, Last) Alfred J. Burrel I					Mary	Name (First Elizat	eth M	yers			
	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 le marke any injury or other traumatic gncs.		19a. Informant's Name/Relationship (7 Donna M. Young / V 20a. Method of Disposition 1 \(\Delta \) Burial 2 \(\Delta \) Cremation 3 \(\Delta \)	Nife Removal from State	20 Wh		e Dri e of her place)	ve, A	Date	Gaith	ersbu	rg, Ma	ryland	
Baltimore,			4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Parklawn 1	Memorial 22. Name and Ockvil Ockvil	Addrose	of English 1	9, 200 Robert 00 Wes	A D	1		1 .	
8760,₺	Physician / Medical Examiner	ledical Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only of the compshock o	a	10.	EPS (ratory arres			Approximation interval Bet Onset and	tween
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (specify)									23d. Date of delivery Month Day Year		
	sign Sign T be	by	Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									ute to the cause of death?		
al Reco	To the Hospital or Attending Physician: The law requivithin 24 hours after death. To the Funeral Director: After this certificete has been completely filled in by the funeral director, page 2 should	Completed								a. Was an autopsy performe Yes 2	prior to completion of cause of death?			
Division of Vital Records,		ıtion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day			28c. Injury at Work?		ng Home 5	(Check only one) ne 5 ☐ Residence 6 ☐ Other (Sp. 18d. Describe how injury occurred			ecify)	
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)								l Route Num	ber,		
		edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									;)		
	or Taking	Σ	29b. Signature and title of certifier		eno, m	D	DO (7/21	1 29d.		ed (Month, I		
	10		30. Name and address of person who con Truong Bao, M.D. 1	3219 Exect	utive Park	Terra	ce,	Germa	ntown,	Maryl	Land 2	20874-	-2647	
	Sta Registr	te ar	31. Date filed (Months Par Year) 9 2	005 32. Hogistra	r's Signature	poste	4							

State of Maryland / Department of Health and Mental Hygien 2005 1 - For State Registrar 29498 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 01 Kathleen Vallie Strebeck 2005 september & /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 220 22 2054 Yrs. Director April 12, 1928 Maryland Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Evantine must be notified at once. 10c. City. Town or Location 10a. State 10b. Count 10d. Inside City Limits Director Maryland Baltimore 1 Tes 2X No Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3831 Clarks Point Rd. 21220 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced ed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Complet (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Linwood Stoup Vallie Maud Clary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew E. Strebeck (Husband) 3831 Clarks Point Rd. Baltimore, Md. 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Gardens Of Faith 9/13/2005 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signatura o Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 0 1407 Old Eastern Avenue Essex, Md. 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mypresdiel **Physician** INTARCT 12 4000 disease or condition resulting in death) /Medical **Examiner** ovener Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21 No Division of Vital 1 ☐ Yes 2 **D**No 1 TYAS Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: ² 1 ☐ Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: injury at Work? After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check one) [2 Medical Ed miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated To the Plack 29c. License number 29b. Signat 29d. Date signed (Month, Day, Year) WD who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Wil Kens Av 152 Himore 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 0 9 2005 Registrar Goaste

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2005 Registrar Amend Item #19a Per fh 8847 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2005 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** vinaton Balt More
If Under 1 Year If Under 24 Hrs. 0 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 240-18-5767 1 ☐ M 2 🛛 F 1915 South Yrs. Director une Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other fraumatic event, the Medical Evantiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2019er 19a Informant's Name/Relationship (Type, Print) (Trandaughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a Informant's Name/Relationship (Type, Print) (Trandaughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a Informant's Name/Relationship (Type, Print) (T ဥ Md. 212/6 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 2005 Mem. Ka * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signarule of Funeral Service Licenses 22. Name and Address of Facility Hom Enter the disease, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sete has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Other: 2 No 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar LIADA

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

- NEUTOW

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05

State of Maryland / Department of Health and Mental Hygiena 29500 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4:05 P M Bell Steward SEPTEMBER 6,2005 Annie /Medical 4a. Facifity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Pay, Year 1920 Birthplace (State or Foreign Country)
 N 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M **X**XF Months Yrs. Director 214-22-2422 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or than "naturel", or items 23s or 28s-f show the Medical Examinar numbe notified at Baltimore N/AMD 1X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 USA 1738 E. Lafayette Avenue death 12. Was Decedent Ever in U.S Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 0.1 1 Never Married 2 Married 1 ☐ Yes **X** XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3€Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self employed Hairdresser 12th other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) : 1 and 2 should be fil Health and Mental H tem 27 Is marked ott McGhee Cora Royster Willie West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. 19a. Informant's Name/Relationship (Type, Print) 356 E. Belvedere Avenue 2nd Floor Item 27 is Gregory McGhee-nephew MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition öΞ 1 XBurial 2 Cremation 3 CRemoval from State ö permit. Page Department of Important: If eny injury or once. MD King Memorial Pk. 9/10/05 Randallstown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARCH F/H-East 21. Signature of Funeral Service Licensee war 1101 E. North Ave., Baltimore, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** DAYS a. PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence of Examine The law requires that the death certificate be executed burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown þ signed I Part If, Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 (Alnpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Ceath 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND 21204 HELDU 132. Registrar's Signature 7601 GBDGLLAH J. Goste State Registrar